Perth and Smiths Falls District Hospital

MRI Fax: 343-800-0067
MRI Booking Clerk: 613-283-2330 ext. 1386

Date Received: _____/_____/_____ (YYYY/MM/DD)

Appt Date/Time: _____/_____/_____at _____:_____

REQUEST FOR MRI CONSULTATION

☐ **IN-PATIENT** Z Number: _____ Floor_____ Room # _____ ER _____ ☐ **OUT-PATIENT**

Surname: _____

First Name: _____

Address: _____

Phone: (h) _____ (m) _____

Health Card (HIN): _____

Date of Birth: _____/_____/_____ (YYYY/MM/DD)

Gender: Female ☐ Male ☐ Other ☐

Weight: _____ lbs/kg -> Table limit is 550lbs/250kg

WSIB (Claim #): _____

Employer: _____

Mobility: Stretcher ☐ Wheelchair ☐ Walk ☐ O2 ☐

Isolation: Airborne ☐ Droplet ☐ Contact ☐

Referring Physician:

Name: _____

Phone Number: _____

Signature: _____

Copy Report to: _____

Copy Report to: _____

INCOMPLETE or ILLEGIBLE requisitions will be returned and will DELAY Study

Examination requested: _____

Indication/Reason and Related Clinical Information:

_____

_____

_____

Is the patient Claustrophobic? No ☐ Yes ☐ If Yes, the ordering MD is to prescribe a medication prior to arrival

Any allergies to **contrast dye**? No ☐ Yes ☐ If Yes, please list _____

→ **If allergy to Gadovist specifically, please follow premedication guidelines.**

If the patient has renal impairment, you MUST provide a recent eGFR (within the last 3 months) as per CAR guidelines. No Bloodwork needed in patients with normal renal function, i.e., expected eGFR of 30 ml/min

eGFR: _____ mL/min Date Drawn(within 60 days of MRI)

PLEASE COMPLETE THE PATIENT SAFETY SCREENING

	No	Yes		No	Yes
Pregnant	☐	☐	Shrapnel/Bullets	☐	☐
Claustrophobic	☐	☐	Aneurysm clip	☐	☐
Requires sedation	☐	☐	Coils, filters, grafts, shunts, or stents	☐	☐
Cardiac pacemaker, defibrillator	☐	☐	Cochlear implant	☐	☐
Prosthetic heart valve	☐	☐	Medical patches, sensors	☐	☐
Vascular access port, catheter	☐	☐	Previous Eye Injury, Metallic foreign body *	☐	☐
Previous Gadolium	☐	☐			

*** If yes, referring physician to order X-Ray of orbits and submit report with requisition.**

FOR RADIOLOGIST USE ONLY:

PROTOCOL: _____ Additional Sequences: _____.

Priority: 1 2 3 4 Gadolinium: No ☐ Yes ☐

Radiologist signature: _____ Date: _____/_____/_____ (YYYY/MM/DD)