MRI REQUISITION

Brightshores Health System

Choosing Wisely Canada™

Fax completed requisition to:

Brightshores Health System Owen Sound Fax: 1-855-702-1968

PATIENT INFORMATION:

Surname: _____ First Name: _____ Middle Initial: _____

Gender: _____ Date of Birth (YYYY-MM-DD): _____ Height: _____ cm Weight: _____ kg

Street Address: _____ Apartment: _____ City: _____ Province: ____ Postal Code: _____

Telephone (Day): _____ (Evening): _____ (Cell): _____

☐ Outpatient ☐ Long Term Care ☐ Inpatient ☐ Isolation Precautions: _____

MRN: _____ Insurance: Province: ___ No.: _____ Research or 3rd Party No.: _____

WSIB: Y ○ N ○ WSIB No.: _____ Date of Injury (YYYY-MM-DD): _____

Mobility: ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Mechanical Lift Preferred Language: ○ EN ○ FR _____ Other

Considerations: ☐ Claustrophobia ☐ Mild Sedation (not provided) ☐ General Anaesthesia ☐ Paediatric

EXAMINATION REQUESTED: _____

Working Diagnosis: _____

Clinical Information: _____

_____

_____

Y ○ N ○ Surgery in exam area

Y ○ N ○ Timed: _____ *Requested Date*

Y ○ N ○ Relevant reports attached

Y N	Please check the following, if applicable
○ ○	Breast feeding
○ ○	History of cancer
○ ○	Medication patch (Foil)
○ ○	Piercings (Remove prior to exam)
○ ○	Pregnant _____ wks.
○ ○	Shrapnel or bullets
○ ○	Surgery in last 6 wks.
○ ○	Tattoos

Y N	Contrast Risk Factors
○ ○	Diabetic
○ ○	Hypertension
○ ○	Impaired renal function
○ ○	MRI contrast reaction
○ ○	On dialysis

Contrast Patient ≥ 60 yrs.:

Recent serum creatinine result: _____

Sample date: _____ YYYY-MM-DD

Y N	Possible MRI Contraindications
○ ○	History of Metal In Eye (*X-ray may be required)*
○ ○	Aneurysm surgery*
○ ○	**Cardiac pacemaker or defibrillator***
○ ○	Cochlear or Ocular Implants*
○ ○	Coils, filters, grafts, stents *
○ ○	Electronic devices, implanted or not implanted*
○ ○	Heart valve*
○ ○	Implanted stimulators, electrodes or pumps*
○ ○	Shunts: ○ Programmable* ○ Non-Programmable*
○ ○	Other _____

*Please forward surgical report and specify the:

Make/Model: _____ **Date:** _____

Institution of surgery: _____

REFERRING PHYSICIAN:

Last Name: _____ First Name: _____ **Signature:** _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Telephone: _____ Fax: _____ Billing No.: _____

COPY TO:

Last Name: _____ First Name: _____ Fax: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

OFFICE USE ONLY

Protocol:

☐ P1 ☐ P2 ☐ P3 ☐ P4 ☐ Timed

Contrast X-rays required: Y ☐ N ☐ Staff Initials: _____

Appointment Date and Time: