ST JOSEPH'S HEALTH CARE LONDON

# MRI REQUISITION

**Bookings**
Telephone: 519-646-6000 ext. 65603
Fax: 519-646-6025

**PATIENT INFORMATION:** (Plate)

Name: _____

PIN#: _____

DOB: _____

HC#: _____

Address: _____

Phone: _____

**PHYSICIAN INFORMATION:**

Print Name (with initials): _____

Signature: _____

Address: _____

_____

Telephone: _____ Fax: _____

☐ INPATIENT ☐ OUTPATIENT

**WSIB:**

Claim Number: _____

Date of Injury: _____

Employer Address: _____

_____

_____

☐ 3rd PARTY / INSURANCE

**AREA TO BE EXAMINED:** _____

**Clinical Problem:** (must be entered) _____

_____

_____

**MRI RESTRICTIONS:** **<u>No patients</u> with implanted defibrillators or weight over 400 lbs or 200 kg.**
**Most pacemakers and pacemaker leads are also contraindicated.**

**The following must be completed before the MRI will be booked.**

1. Does the patient have a history of impaired renal function? ☐ Yes ☐ No
2. Is the patient currently on dialysis? ☐ Yes ☐ No
3. Is the patient over 70 years of age? ☐ Yes ☐ No
4. Does the patient have hypertension or diabetes? ☐ Yes ☐ No
5. Does the patient have any of the following implants or clips? ☐ Yes ☐ No
   (a) If yes, please check the appropriate box:
   ☐ GI Bleed Clip ☐ Implanted Stimulator ☐ IVC Filter ☐ Stent
   (b) ☐ Cerebral Aneurysm Clip ☐ Yes ☐ No
   If yes, the following information on the aneurysm clip is required.
   Make: _____ Model: _____ Date of Insertion: _____
6. Is the patient pregnant? ☐ Yes ☐ No
7. Has the patient had previous surgery in the area of imaging? ☐ Yes ☐ No
8. Patient weight: _____ lb / kg?
9. Any previous relevant MRI or CT? If yes where/when? _____ ☐ Yes ☐ No
10. Does the patient require sedation for their MRI exam? ☐ Yes ☐ No
11. Has patient ever had metal in his/her eye? If yes, orbital xray required. ☐ Yes ☐ No

**Please fill out the following to accurately describe the patient's current situation.**

1. Are you requesting a timed follow-up procedure (eg. 6 month follow-up)?

   **If yes,** date requested: _____

   **If no,** how would you rate the urgency or relative priority of this patient: *(circle one)*

   **(Not Urgent At All) 10 9 8 7 6 5 4 3 2 1 (Extremely Urgent)**

**MRI Exam Date:** _____

**-- Radiologist's Use Only --**

**Booking Priority:**

☐ **1** Emergency ☐ **3** Semi Urgent ☐ **4** Non Urgent
☐ **2** Urgent ☐ **3T** Semi Urgent/Timed ☐ **4T** Non Urgent/Timed
☐ **2T** Urgent/Timed

**Protocol**

☐ PM
☐ 1 slot ☐ 2 slot ☐ 3 slot
**Day:** ☐ Neuro ☐ Ortho ☐ Body
**Breast:** ☐ Tumour ☐ Implant ☐ Biopsy

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