MRI Consultation Request

nova scotia health authority

IWK Health Centre

Requisition received _____

Appointment _____

MRI Site _____

Patient Information

HC# _____ Province of coverage _____

HC expiry date _____ DOB (yyyy/mm/dd) _____

☐ NS-WCB# _____ ☐ Private Insurance Carrier _____

☐ Can Military# _____ Group# _____ Member# _____ Exp _____

Patient Name _____

Surname *First* *Middle*

Mailing Address _____

Telephone# _____ / _____ / _____

Home *Cell* *Work*

Patient Weight _____ kg or lb Gender _____

☐ *Ambulatory* ☐ *Wheelchair* ☐ *Stretcher* ☐ *Isolation*

MRI Examination Requested

History and Provisional Diagnosis

Requesting Physician Information

PRINT NAME _____

Telephone # _____

Fax # _____

Pager # _____

Physician's SIGNATURE _____

Date of request (yyyy/mm/dd) _____

Copy of report to _____

Safety Information *(MUST be filled out completely)*

Penetrating injury to eye involving metal, NOT yet cleared by an eye doctor or x-ray ☐ Y ☐ N

If not cleared, please **order orbit x-rays prior to MRI.*

Does patient work as grinder or welder ☐ Y ☐ N

Orbit x-rays **may be required prior to MRI.*

Attach details for implanted devices (Make, Model)

Pacemaker, internal defibrillator, leads ☐ Y ☐ N

Cerebral aneurysm clips ☐ Y ☐ N

Inner ear implants / cochlear implant ☐ Y ☐ N

Eye surgery (detached retina, etc.) ☐ Y ☐ N

Neuro, bio or spinal stimulator ☐ Y ☐ N

Medication pump for insulin, chemo or pain ☐ Y ☐ N

Orthopedic hardware / joint replacement ☐ Y ☐ N

Any other implants (coils, filter, stent, mesh, pins, IUD, penile, pessary, etc.) _____

Shrapnel, bullet, bb, metal shaving in body ☐ Y ☐ N

Previous relevant surgeries _____

Is the patient claustrophobic? ☐ Y ☐ N

**Oral sedation, if needed, must be prescribed by referring physician.*

Require general anesthetic ☐ Y ☐ N

Is the patient pregnant? ☐ Y ☐ N

**If yes, number of weeks* _____

Required information for CONTRAST MEDIA use

Renal disease ☐ Y ☐ N

Currently on dialysis ☐ Y ☐ N

Diabetic ☐ Y ☐ N

CREATININE _____ Date (yyyy/mm/dd) _____

INCOMPLETE FORMS WILL BE RETURNED, AND RESULT IN DELAYS FOR THE PATIENT

Additional Information is required before booking:

☐ *The safety information is not complete.*

☐ *Not legible*

☐ *Inadequate history*

☐ *No doctor signature*

☐ *Orbits not cleared yet*

☐ *Additional screening required for 3T MR*

Radiologist Instructions Rad _____

Priority P1 P2 P3 P4

Magnet 1.5T 3.0T

Protocol _____

Notes:

Technologist Instructions Tech _____

Exam codes _____

Time required for exam _____

Notes: