

Request for MRI Consultation

(Magnetic Resonance Imaging)

HNHB LHIN

| | | |
|---------------------|----------------------------|-----|
| Last Name | First Name | |
| HIN/HCN/OHCN/OHIP # | Date of Birth (yyyy/mm/dd) | |
| Address | | |
| City / Province | Postal Code | |
| Phone Number: | Mobile Number: | |
| Gender | Weight (kg) | Age |

REQUEST TO: Referral Date: _____

- Brantford General Hospital**
Phone: 519-751-5544
Ext: 2287
Fax: 519-751-5813
- Greater Niagara General**
Phone: 905-378-4647
Fax: 905-358-4911

- Hamilton General Hospital**
Phone: 905-521-2100
Ext: 46061
Fax: 905-523-6241
- Joseph Brant Hospital**
Phone: 905-336-4126
Fax: 905-336-4148
- Juravinski Hospital & Cancer Centre (Hamilton)**
Phone: 905-557-1484
Ext: 41484
Fax: 905-387-8813
- McMaster University Medical Centre & Children's Hospital (Hamilton)**
Phone: 905-521-5059
Ext: 75059
Fax: 905-521-5057
- St. Catharines Hospital**
Phone: 905-378-4647
Fax: 905-684-6990
- St. Joseph's Healthcare (Hamilton)**
Phone: 905-521-6074
Fax: 905-521-6166

Referring Physician: _____ Printed Name Signature & Designation Unit: _____ Phone: _____

Hospital/Other Facility: _____ Phone: _____ Fax: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Send Additional Report to: Primary Care Physician Other: _____ Printed Name Phone Number Fax

Exam Payee:
 OHIP WSIB # Self Third Party
Specify: _____

Patient Routing:
 Hospital preference: _____
 Next available appointment at any hospital

Exam Requested (be specific):

Current Patient Location:
 Inpatient Outpatient Emergency

Language Preferred: English French Other: _____
Interpreter Required? Yes No

Clinical Information / Relevant History:

These Safety Questions must be answered by the patient:

Check Yes or No to all questions: YES NO

- Have you had a previous MRI? YES NO
- Have you ever had a metallic foreign body in your eye? YES NO
If yes, was it removed? YES NO
- Are you pregnant or breastfeeding? YES NO
- Are you claustrophobic requiring sedation? YES NO
- Do you require any physical aids (wheelchair, stretcher, etc.)? YES NO
- Do you have any drug allergies? YES NO
If yes, Please indicate: _____

Please answer all of the following questions:

- Known Renal Disease? YES / NO
- Known Diabetes? YES / NO
- On Metformin? YES / NO

If the answer to any of the above question(s) is yes, then please provide eGFR / Creatinine results within 3 months:

eGFR: _____ ml/min/1.73² Date: _____ (yyyy/mm/dd)

Creatinine: _____ ml/min/1.73 Date: _____ (yyyy/mm/dd)

Relevant tests to date:

| Study (e.g. CT/MRI/Xray) | Date (yyyy/mm/dd) | Location |
|--------------------------|-------------------|----------|
| | | |
| | | |
| | | |

Do you have any of the following?

- Heart pacemaker / defibrillator? YES NO
- Brain aneurysm clip? YES NO
- Spine Neurostimular YES NO
- Body jewelry, piercings, tattoos? YES NO
- Ear implants (excluding hearing aids)? YES NO
- Other implanted device or surgeries? YES NO

Details (type of implant or surgery, year of procedure, etc.):

Additional Information:

FOR MRI USE ONLY

Reviewed by: _____ Printed Name Signature & Designation Date: _____ (yyyy/mm/dd)

Priority: 1 2 T2 3 T3 4 T4 Test Date: _____ (yyyy/mm/dd) Test Time: _____ (hh:mm)

Clinical Indication: Cancer Other: _____

Protocol: _____ Radiologist (printed): _____ Date Protocolled: (yyyy/mm/dd)

Additional Comments: _____ Signature: _____