Perth and Smiths Falls District Hospital

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

Date Received: _____
Appt Date and Time: _____

REQUEST FOR MR CONSULTATION

IN-PATIENT ☐ Floor_____Room #_____ER_____ Stretcher ☐ Wheelchair ☐ Walk ☐ O2 ☐

OUTPATIENT ☐ **Isolation:** Airborne ☐ Droplet ☐ Contact ☐

Surname: _____
First Name: _____
Address: _____
Phone #: (h) _____(c) _____
Date of Birth: _____
PT Weight_____lbs /kg *Table limit is 550lbs/250kg

Z#:_____ Female ☐ Male ☐

Ref Physician: _____Phone# _____

Physician Signature: _____
Copy Report to: _____
WSIB (Claim #): _____Employer:_____

INCOMPLETE or ILLEGIBLE requisitions will be returned and will DELAY Study

Examination requested: _____

Indication/Reason and Related Clinical Information:

_____
_____
_____

Is the patient Claustrophobic? Y or N *If yes, physician to prescribe medication prior to MRI arrival
Any allergies to Contrast Dye? Y or N *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.

eGFR — Date Drawn (YYYY/MM/DD):_____(within 60 days of MRI) **Results:** _____

PLEASE COMPLETE THE PATIENT SAFETY SCREENING BELOW

	Y	N
Claustrophobic		
Require sedation		
Aneurysm Clip		
Cardiac pacemaker/Defibrillator		
Prosthetic heart valve		
Metallic foreign body		
Pregnant		
Vascular access port/catheter		
Previous Gadolinium		

	Y	N
Shrapnel/Bullets		
Surgical aneurysm clip		
Previous Eye Injury/foreign body		
Coils, Filters, Grafts, Shunts or Stents		
Cochlear Implant		
Medication Patches/Sensors		
Previous Eye Injury/foreign body*		

***If yes, referring physician to order XRay of orbits and submit report with this requisition.**

FOR RADIOLOGIST USE ONLY:

PROTOCOL: _____ Additional Sequences: _____

Priority 1 2 3 4 Gadolinium: Yes ☐ No ☐

Radiologist Signature: _____ Date: _____ (yyyy/mm/dd)