Kingston MRI

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REQUISITION FORM-W

PATIENT & PHYSICIAN INFORMATION

Name: (last name first) _____ **DOB:** (yyyy/mm/dd)_____
Address: _____ **Gender:** Male / Female
_____ **Phone(H):** (_____)_____
Health Card #: _____ **OHIP?: Y/N** **Phone(W):**(_____)_____
Check one: Walking [ ] Wheelchair [ ] Stretcher [ ]
Is this a WSIB exam? Yes [ ] No [ ] **If yes, claim #:** _____
Physician Name: _____ **Phone #:** (_____)_____ **Billing #:**_____

REGION TO BE EXAMINED (select ALL that apply):

[ ] Brain	[ ] C-spine	[ ] Adrenals	[ ] Knee	[ ] Sinuses
[ ] Orbits	[ ] T-spine	[ ] Kidneys	[ ] Shoulder	[ ] Chest
[ ] Nasopharynx	[ ] L-spine	[ ] Pancreas	[ ] Hips	[ ] Urinary Bladder
[ ] Oropharynx	[ ] Liver	[ ] Uterus	[ ] Ankle	[ ] Breast
[ ] Larynx	[ ] Biliary Tree	[ ] Ovaries	[ ] Wrist	[ ] Other:

[ ] MR Angiogram (specify site): _____ _____

PRIORITY CODE (1 Emergent ←-----→Elective 5): 1 2 3 4 5 **Or** specific date: _____
CLINICAL HISTORY (please be specific):

_____
_____
_____

WORKING DIAGNOSIS:

_____

RELEVANT TESTS TO DATE (previous MR/CT/US/Angio/Nuc Med – specify site):

_____

Does the patient require sedation? (To be provided by the referring physician): Yes [ ] No [ ]

PATIENT SAFETY SCREENING (To be completed by referring physician on behalf of patient)

Do you have:	**YES**	**NO**		**YES**	**NO**
Cardiac pacemaker/leads	___	___	Penile Implants	___	___
Artificial heart valve	___	___	Other implanted devices: _____		
Aneurysm clips	___	___	**Any surgery?** Yes[ ] No[ ] If Yes, please describe:		
Port-a-cath/Swan Ganz Catheter	___	___	_____		
Dentures/braces	___	___	_____		
Neurostimulator	___	___	**Are you/could you be pregnant?** Yes [ ] No [ ]		
Cochlear implants	___	___	**Are you claustrophobic?** Yes [ ] No [ ]		
Shrapnel/bullets	___	___	**Current weight**: _____		

Do you have a patch to deliver medication? Yes [ ] No [ ], **If Yes, it must be removed during the scan.**
Have you ever worked with metal / Has metal ever gone in or close to your eyes? Yes [ ] No [ ], **If Yes**, referring physician to order **x-ray of the Orbits** and submit report with this requisition.
Referring MD signature: _____ **Date** (yyyy/mm/dd): _____

IMAGING PROTOCOL (To be completed by MR radiologist)

Priority Code: 1 2 3 4 5 **OR** completed by (date): _____
Protocol: _____
Additional sequences: _____
Gadolinium: Yes [ ] No [ ] If Yes, dose: _____ Monitor: Yes[ ] No[ ]
Radiologist signature: _____ Date (yyyy/mm/dd): _____