

## **MRI - Diagnostic Imaging Department** 3001 Hospital Gate, Oakville, ON L6M 0L8

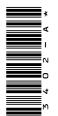
Telephone: 905-338-4601

## **MRI REQUISITION**

## Fax all MRI requests to 905-815-5103

Incomplete / illegible requisitions will be returned

|  | ,  | lay to booking the   | appointmen                             | nt                       |  |
|--|--|--|--|--------------------------|--|
| Ph   | ysician's Name:  |  |  |                          |  |
| Ad   | dress:   |  |  |                          |  |
| Pos  | stal Code:   |  |  |                          |  |
| Ph   | one:   | Fax:   |  |                          |  |
| Со   | pies to:   |  |  |                          |  |
| Date:  |  |  |  |                          |  |
| 1.   | REGION OF INTER  | EST:   |  |                          |  |
| 2.   | CLINICAL HISTOR' SPECIFIC QUESTIO                      | Y; DIFFERENTIAL D<br>DNS?  | IAGNOSIS;                              |                          |  |
| In general, MRI is of no value in the management of osteoarthritis (OA). Referral to the Hip & Knee Rapid Access Clinic should be considered. www.mhcentralintake.com  3. RELEVANT PRIOR IMAGING STUDIES?  |  |  |  |                          |  |
| Halton Healthcare  External  Requisition must include external reports or booking will be delayed.  MSK studies (excluding the spine) require X-rays within 6 months.  For follow-up of or for comparison to previous outside studies, the patient must bring the outside IMAGES to appointment or a delay in interpretation may result while we attempt to obtain the images. |  |  |  |                          |  |
|  | FOR STUDIES WHIC (generally breast, abdo               | H MAY REQUIRE IV   | CONTRAS                                | T:                       |  |
| a)   | Previous reaction to MR<br>If yes: a contrast risk for |  |  | No □                     |  |
| b)   | If known renal dysfunction                             | on, is eGFR < 30?  | Yes □                                  | No □                     |  |
| c)   | Dialysis patients:                                     | Hemodialysis □   | Peritoneal                             | Dialysis □               |  |
| d)   | Acute Kidney Injury?                                   |  | Yes □                                  | No □                     |  |
| Đ!   | ysician Signature:                                     |  |  |                          |  |
|  |  | Systemic Fibrosis (I   | NSF)                                   |                          |  |
|  | i disease with eGF                                     | vith acute kidney injury (AR < 30 mL/min/1.73m2, contrast agents (GBCA) to | or on dialysis, thus<br>sed by our fac | ne newer<br>ility can be |  |



considered necessary and no alternative test is available. Given this risk profile, the CAR no longer recommends screening for renal dysfunction. For hemodialysis patients, post procedure dialysis is still recommended, and for peritoneal dialysis, alterations in PD prescription might be considered on a per patient basis.

| Name:  | N         | //F/X |  |  |  |
|--|-----------|-------|--|--|--|
| Address:   |           |       |  |  |  |
|  |           |       |  |  |  |
| Phone (H) (Cell)   |           |       |  |  |  |
| Do we have your consent to leave information pertaining to your a<br>Yes - Indicate phone #  | appointm  | ent?  |  |  |  |
| D.O.B Health Card #:   |           |       |  |  |  |
| Unit #:  |           |       |  |  |  |
| OPTION – Appointment will be scheduled at one of the following earliest available appointment Milton District Hospital or Oakville Trafal Hospital  WSIB / Third Party □ Yes □ No Claim #:   | lgar Memo | orial |  |  |  |
| Patient Safety Screening Questions   | i         |       |  |  |  |
| All questions must be answered or request will be re   |           |       |  |  |  |
| History of orbital injury by metal requiring medical attention?  | Yes       | No    |  |  |  |
| If metal not clearly removed – obtain orbital radiographs.   |           |       |  |  |  |
| <ol> <li>Is the patient claustrophobic?         If "Yes", consider prescription for PRN medication (we do not provide). If Rx provided, patient must be accompanied.     </li> </ol>   |           |       |  |  |  |
| Are there other potential difficulties? Describe   |           |       |  |  |  |
| <ol> <li>Pregnancy status: If "Yes" or unclear at the time of exam, the study<br/>may be deferred.</li> </ol>  | / <b></b> |       |  |  |  |
| 5. Do you have any of the following:  Cardiac Pacemaker.  Artificial Cardiac Valve.  Retained Pacing Wires.  Brain Aneurysm Clips.  Neurostimulator.  Cochlear (ear) Implants.  Shrapnel / Bullets.  Metal rods, plates, screws, wires.  List any Implanted Devices: |           | 0 0 0 |  |  |  |
| Type and date of <u>ALL</u> surgeries and any implanted devices from procedures:   |           |       |  |  |  |
| 7. Patient's WEIGHT: lbs. (Maximum of 550 lbs.)  |           |       |  |  |  |
| 8. Is an interpreter required?   |           |       |  |  |  |
| Sign Language Interpreter?   |           |       |  |  |  |
| * Please describe:   |           |       |  |  |  |
| Patient /Substitute Decision Maker (SDM) Signature:  |           |       |  |  |  |
| SDM Contact #  |           |       |  |  |  |
| MRI APPOINTMENT DATE:  |           |       |  |  |  |
| Time:Site: □OAKVILL  | .E □M     | ILTON |  |  |  |

Form # H3402-A Nov 2019C