HealthView
MEDICAL IMAGING

MRI – Diagnostic Imaging Requisition

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A. PATIENT INFORMATION	
Name:	Address:
Telephone:	
DOB:	HCN#:
Height & Weight:	☐ Restricted Mobility:

B. REFERRING PHYSICIAN	
Name:	Telephone:
Address:	Fax:

C. EXAM INFORMATION – *Must be completed by referring physician*

Area(s) to be scanned:	**Clinical indication/Questions to be answered:**

D. SCREENING QUESTIONS – *Must be completed by referring physician*

Incident with Metal in Eyes or Body	Yes	No	***(If "Yes", X-ray must be arranged prior to MRI)***		
Pacemaker/ ICD	Yes	No	Lumbar Spine Surgery	Yes	No
Brain Implant (aneurysm clips/coils)	Yes	No	Insulin Pump/Sensor	Yes	No
Eye or Ear Implant	Yes	No	Other Implants:		

CLAUSTROPHOBIC - PLEASE PROVIDE APPROPRIATE MEDICATION IF REQUIRED.
IMPLANT CARD/OPERATIVE REPORT MAY BE REQUIRED PRIOR TO SCHEDULING APPOINTMENT.

E. CONTRAST SCREENING QUESTIONS – *Must be completed by referring physician*

Diabetic	Yes	No	Cardiovascular Disease/Hypertension	Yes	No
Renal Disease	Yes	No	Hepatic Disease	Yes	No
Dialysis	Yes	No	Protein in Urine	Yes	No
Age >60	Yes	No	Gout	Yes	No

PROVIDE eGFR IF AVAILABLE (RECENT WITHIN 3 MONTHS):

Creatinine: _____ umol/L eGFR: _____ Collection Date: _____

Physician Signature:	**Date:**

INTERNAL USE ONLY

Tech Notes:	MRI Fee:	Acc#:
	Appt Date:	Appt Time:

☐ CONTRAST		Protocol:
	Type&Amt:	
	Lot/Exp:	
	Injection Site:	
	Inject Date/Time:	