Lennox & Addington County General Hospital

DIAGNOSTIC IMAGING– **MRI**

Tel: 613-354-3301 x 630

Patient Name:

DOB:
HCN:
Address:
Phone/Cell #:

☐ Non OHIP Patient:

☐ WSIB #:

Physician Name: _____

Physician Signature: _____

OHIP Billing Physician Name/#:_____

Physician Contact #: _____

Physician Fax #: _____

Date of Referral: _____

Report Copies To: _____

****Message capable Physician phone # to confirm receipt of urgent results:**

_____

**if absent, urgent result receipt confirmation delays may occur

INCOMPLETE or ILLEGIBLE requisitions WILL BE RETURNED and may DELAY THE STUDY .
PLEASE FAX COMPLETED REQUISITION TO 613-354-8231

BODY PART(S) TO BE IMAGED-BE SPECIFIC :_____

CLINICAL INDICATION (incl. relevant prior surgery):

☐ Patient is pregnant: _____ weeks

Requested date/time frame:

Note: DI Department triages requests based on provided history

Please Circle One:

P2 = Within 48hr ***# required*

P3 = Within 10 days = **P3c Oncology**

P4 = Routine = **P4c Oncology**

PATIENT SCREENING (complete with patient) ***YES = not performed @ LACGH***

YES / NO	PACEMAKER*/ICD*/LEADS*/Loop*
YES / NO	STIMULATION DEVICE* (NEURO/BIO)
YES / NO	INNER EAR SURGERY/COCHLEAR IMPLANT*
YES / NO	PRIOR BRAIN ANEURYSM CLIPS*
YES / NO	OTHER BRAIN SURGERY –SPECIFY_____
YES / NO	PRIOR VASCULAR SURGERY –SPECIFY_____
YES / NO	SHRAPNEL OR BULLETS-WHERE_____
YES / NO	HAVE YOU **EVER** HAD A PENETRATING EYE INJURY FROM METAL? **IF YES**, **ORBITAL XRAY IS REQUIRED UNLESS** A PREVIOUS MRI OR CT HEAD COMPLETED AFTER EXPOSURE/EVENT. CT/MRI HEAD EXAM DATE:_____

PATIENT SCREENING (complete with patient)

YES / NO	CURRENTLY ON DIALYSIS? LOCATION/FACILITY_____
YES / NO	CLAUSTROPHOBIC? ☐ PRESCRIPTION FILLED *(Ativan 1 OR 2mg PO prn)* ☐ GIVEN TO PATIENT
YES / NO	KNOWN **GADOLINIUM** CONTRAST ALLERGY? **IF YES** (Circle & Specify Below) **Minor Reaction** (ie. Hives, Itchy, nausea) **Major Reaction** (ie. Anaphylaxis) ▪non contrast exam only performed

PATIENT WEIGHT _____ lbs/kg

MRI table weight restriction: 550 lbs/250kg

Appointment Date & Time: Date Received: Date Notified: