Request for MRI Consultation

(Magnetic Resonance Imaging)

HNHB LHIN

Last Name	First Name
HIN/HCN/OHCN/OHIP #	Date of Birth (yyyy/mm/dd)
Address	
City / Province	Postal Code
Phone Number:	Mobile Number:
Gender	Weight (kg) Age

REQUEST TO: **Referral Date:** _____

☐ **Brantford General Hospital**
Phone: 519-751-5544
Ext: 2287
Fax: 519-751-5813

☐ **Greater Niagara General**
Phone: 905-378-4647
Fax: 905-358-4911

☐ **Hamilton General Hospital**
Phone: 905-521-2100
Ext: 46061
Fax: 905-523-6241

☐ **Joseph Brant Hospital**
Phone: 905-336-4126
Fax: 905-336-4148

☐ **Juravinski Hospital & Cancer Centre (Hamilton)**
Phone: 905-557-1484
Ext: 41484
Fax: 905-387-8813

☐ **McMaster University Medical Centre & Children's Hospital (Hamilton)**
Phone: 905-521-5059
Ext: 75059
Fax: 905-521-5057

☐ **St. Catharines Hospital**
Phone: 905-378-4647
Fax: 905-684-6990

☐ **St. Joseph's Healthcare (Hamilton)**
Phone: 905-521-6074
Fax: 905-521-6166

Referring Physician: _____ (Printed Name) _____ (Signature & Designation) Unit: _____ Phone: _____

Hospital/Other Facility: _____ Phone: _____ Fax: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Send Additional Report to: ☐ Primary Care Physician ☐ Other: _____ (Printed Name) _____ (Phone Number) _____ (Fax)

Exam Payee:
☐ OHIP ☐ WSIB # _____ ☐ Self ☐ Third Party Specify: _____

Patient Routing:
☐ Hospital preference: _____
☐ Next available appointment at any hospital

Exam Requested (be specific):

Current Patient Location:
☐ Inpatient ☐ Outpatient ☐ Emergency

Language Preferred: ☐ English ☐ French ☐ Other: _____
Interpreter Required? ☐ Yes ☐ No

Clinical Information / Relevant History:

Please answer all of the following questions:

1) Known Renal Disease? **YES / NO**
2) Known Diabetes? **YES / NO**
3) On Metformin? **YES / NO**

If the answer to any of the above question(s) is yes, then please provide eGFR / Creatinine results within 3 months:

eGFR:_____ ml/min/1.73² Date:_____ (yyyy/mm/dd)

Creatinine:_____ ml/min/1.73 Date:_____ (yyyy/mm/dd)

Relevant tests to date:

Study (e.g. CT/MRI/Xray)	Date (yyyy/mm/dd)	Location

These Safety Questions must be answered by the patient:

Check Yes or No to all questions:	**YES**	**NO**
1. Have you had a previous MRI?	☐	☐
2. Have you ever had a metallic foreign body in your eye?	☐	☐
If yes, was it removed?	☐	☐
3. Are you pregnant or breastfeeding?	☐	☐
4. Are you claustrophobic requiring sedation?	☐	☐
5. Do you require any physical aids (wheelchair, stretcher, etc.)	☐	☐
6. Do you have any drug allergies? If yes, Please indicate: _____	☐	☐
Do you have any of the following?		
7. Heart pacemaker / defibrillator?	☐	☐
8. Brain aneurysm clip?	☐	☐
9. Spine Neurostimular	☐	☐
10. Body jewelry, piercings, tattoos?	☐	☐
11. Ear implants (excluding hearing aids)?	☐	☐
12. Other implanted device or surgeries?	☐	☐

Details (type of implant or surgery, year of procedure, etc.):

_____

Additional Information:

FOR MRI USE ONLY

Reviewed by: _____ (Printed Name) _____ (Signature & Designation) Date: _____ (yyyy/mm/dd)

Priority: **1** **2** **T2** **3** **T3** **4** **T4** Test Date: _____ (yyyy/mm/dd) Test Time: _____ (hh:mm)

Clinical Indication: ☐ Cancer ☐ Other: _____

Protocol: _____ Radiologist (printed): _____
Date Protocolled: (yyyy/mm/dd)

Additional Comments: _____ Signature: _____