fraserhealth

MAGNETIC RESONANCE (MRI) REQUISITION

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Hospital Appt. Date Time

☐ Yes ☐ No
Interpreter Needed Language?

☐ Yes ☐ No
Authorized to contact patient Phone #?

Please arrive 20 minutes early for registration/parking.

Date Ordered	Date Required	Date Received
Sex M F	Surname	First Name
Address		
City		Home Phone
Date of Birth (dd/mmm/yyyy)		Work Phone
Medical Plan Number		WCB / ICBC Claim Number

☐ MSP ☐ WCB ☐ ICBC ☐ PATIENT ☐ OTHER

EXAM REQUESTED: Relevant History / Reason

Please Indicate Pertinent Exams Below

☐ MRI ☐ CT ☐ Xray ☐ Angio ☐ Nuc Med ☐ Other

Date: _____ Location: _____

Patients requiring IV Contrast with a history of:

1. Renal disease (solitary kidney, transplant, tumour)
2. Age > 60
3. History of Hypertension
4. History of Diabetes
5. History of severe hepatic disease / liver transplant

A recent (in the last 6 weeks) Estimated Glomerular Filtration Rate (eGFR) is required.

eGFR result: _____ **Date:** _____

Examples of Exams that require Contrast:

• Breast • Tumour Assessment • Abdomen • Post Op Spine • Vascular

(Most MSK, spine or routine neuro exams do not require Contrast)

ESSENTIAL PRE-EXAMINATION INFORMATION	
Cardiac Pacemaker or Defibrillator	☐ Yes ☐ No
Cerebral Aneurysm Clip	☐ Yes ☐ No
Internal electrodes or wires	☐ Yes ☐ No
Middle Ear Prosthesis or Cochlear Implant	☐ Yes ☐ No
Metallic Orbital Foreign Body	☐ Yes ☐ No
Shrapnel, Bullet	☐ Yes ☐ No
Intravascular Coil, Stent, or Filter	☐ Yes ☐ No
Breast Tissue Expander	☐ Yes ☐ No
Implanted infusion pumps or stimulators	☐ Yes ☐ No
Other: _____	
Is the Patient Pregnant?	☐ Yes ☐ No
Is the Patient Breastfeeding?	☐ Yes ☐ No
Is the Patient Claustrophobic?	☐ Yes ☐ No
Patient's Weight? _____ (max 350lbs)	

Requesting Physician: _____ Billing# _____ Additional Copies: _____
(Please print)

Physician Signature: _____ Phone# _____ Fax# _____

DEPARTMENT USE ONLY

Priority ☐ P1 ☐ P2 ☐ P3 ☐ P4 ☐ Specified date: _____

ORBITAL X-rays required: ☐ Yes ☐ No

Previous Films/Req required: ☐ Yes ☐ No

☐ Comments: _____

Radiologist Protocol

IV Contrast: ☐ Yes ☐ No

_____

Mnemonic(s):

Booking:

☐ Films
☐ Reports
☐ Lab

Technologist Notes:

_____

Date/Time Req. Rcv'd (dd/mmm/yyyy)

Patient Type: ☐ ER ☐ IP ☐ OP/OH

Priority: 1 2 3 4 Specified date

Discharged OH _____

OP Related Delay: ☐ Yes ☐ No

Stores # 316458