Royal Victoria Regional Health Centre

Appointment

Date: _____

Time: _____

Scanner: 1.5T 3T

Request for MRI Consultation

Department of Diagnostic Imaging
Royal Victoria Regional Health Centre
Tel. (705) 739.5610
Fax. (705) 739.5649

☐ **INPATIENT** *must be faxed to: (705) 792-3339 ☐ **OUTPATIENT**

Name: _____ Gender: ☐ M ☐ F
Address: _____
City: _____ Postal Code: _____
Health Card #: _____
Date of Birth *(DD/MM/YYYY)*: _____
Home #: _____ Cell #: _____
E-mail: _____
Please allow 2 weeks to receive notification of appointment

Area to be examined **(be specific)**: _____
Diagnostic Question/Clinical History: _____

Are you requesting a **timed follow-up** procedure (e.g., 6 month follow-up)? *If yes, date requested (DD/MM/YYY):* _____

Medical History Assessment for out-patient:
Dialysis ☐ YES ☐ NO

Medical History Assessment for in-patient:
Dialysis ☐ YES ☐ NO
Serum Creatinine: _____ Date DD/MM/YY:_____

Referring Physician (please print): _____
Address: Collingwood General and Marine Hospital 459 Hume St, Collingwood, ON L9Y 1W9
Tel #: ~~(705) 445-2550~~ Fax #: _____

Physician Signature: _____

Patient Weight: _____ **Patient Height**: _____

Ambulation:
☐ Walk ☐ Wheelchair ☐ Stretcher ☐ MEDICAL LIFT

Please list previous pertinent Imaging (MANDATORY)
External reports MUST be provided.

	What	Where
MRI		
CT		
Xray/Mammo		
Ultrasound		
Other		

If the following information changes between now and the appointment notify the MRI Department.
Inaccurate information can result in appointment cancellation the day of exam.

Indicate if the patient has the following:	Yes	No		Yes	No
1. Previous reaction to contrast used for **MRI?** *If yes, state the reaction type:* _____	☐	☐	10. Coils, Filters, or Stents? *If yes, provide the location in the body:* _____	☐	☐
2. Claustrophobia? *If yes, physician to prescribe sedation*	☐	☐	11. Neurostimulation System/Other Stimulation Device? Type: _____	☐	☐
3. Have you ever had metal go into your eye that was not removed by a doctor? ***If yes, attach orbit x-ray report***	☐	☐	12. Programmable shunt? *(spinal or intraventricular)*	☐	☐
			13. IUD Type:	☐	☐
4. Any metallic fragment or foreign body? *(shrapnel, bullets)*	☐	☐	14. Spinal surgery? ***Level of sx:*** _____ ***Date:*** _____	☐	☐
5. Currently pregnant?	☐	☐	15. Breast Tissue expander? Type: _____	☐	☐
6. Pacemaker/Defibrillator/ICD?	☐	☐	16. Drug infusion pump or glucose monitor?	☐	☐
7. Prosthetic Heart Valve, Cardiac Closure or Occluder Device? Type: _____	☐	☐	17. Any type of prosthesis? *(eye, penile, etc.)* *If yes, explain:* _____	☐	☐
8. Cerebral Aneurysm Clips?	☐	☐	18. Any other metallic, magnetic or electronic implant? *If yes, explain:* _____	☐	☐
9. Cochlear (ear) implant?	☐	☐			

List **all** previous surgeries and implants.

☐ No previous surgery None

For any implant, provide surgery date/hospital so we may confirm MRI compatibility. Provide OR record to expedite booking.

Verification of screening will be done at appointment

Patient/SDM Signature: _____ Technologist Signature: _____ Date: _____

For Radiologist Use ONLY:

☐ **P1** ☐ **P2** ☐ **P3** ☐ **P4** ☐ **T** _____

Protocol

☐ Cancer Stage/Diagnosis ☐ Breast Cancer Screen ☐ Other

For Booking Use Only:

☐ 20 ☐ 30 ☐ 45 ☐ 60 ☐ 75
☐ GAD ☐ 1.5T
☐ BUSCOPAN ☐ 3T
☐ WEEKEND ☐ GA
☐ WEEKDAY
☐ BOOKING TIME

_____