DIAGNOSTIC IMAGING: MAGNETIC RESONANCE IMAGING (MRI)

Reset

Exceptional Care
Inspired by You

Belleville General Hospital
265 Dundas St. E
Belleville, ON
K8N 5A9
613-969-7400 ext 2802

ORDERING PHYSICIAN (please print)

ORDERING PHYSICIAN (please sign)

COPIES TO:

DATE: Sep 12, 2013

Name:

DOB:

Phone:
Cell:
Work:

HCN:

Address:

WSIB #:

FAX this requisition to 613-969-5561

A BOOKING CANNOT BE MADE UNLESS THIS REQUISITION IS COMPLETED IN FULL.

If a scan is requested because of abnormalities found on imaging studies performed at a facility other than QHC, the relevant reports and imaging studies must accompany the requisition or patient.

TABLE WEIGHT LIMIT – 200 Kilo/ 440 LBS. As a safety precaution, patients exceeding this weight limit cannot be done

EXAM REQUESTED:

CLINICAL INFORMATION / HISTORY:
Patient Location: ○ER ○ Inpatient ○Outpatient

DEPARTMENT USE ONLY

Protocol:

Priority: 1 2 3 4

Time: 15 20 25 30 35 40 45 50 55 60 65 70

Date Requisition Received: _____

BOOKING DATE: **TIME:**

☐ **CREATININE needed**

☐ **Insufficient Clinical Data** ☐**MRI not indicated**

Notes:

Safety questions to be completed by the patient

	Y	N
Have you ever had metal in your eye?	○	○
If yes, orbital X-rays are required pre MRI unless patient has had MRI at QHC after exposure to metal		
Are you claustrophobic?	○	○
If yes, please see your Dr. for a sedative		
Any known history of kidney disease?	○	○
Do you have:		
A pacemaker or defibrillator?	○	○
Brain aneurysm clip?	○	○
Cochlear implant?	○	○
A neurostimulator device?	○	○
Shrapnel or bullets?	○	○
Are you pregnant or breastfeeding?	○	○
Any implanted devices?	○	○

Please specify:_____

Please list all previous surgeries with dates:

Surgery	**Date**

Are you available on short notice? ○ **Y** ○ **N**

Contact Number _____

Pt. Weight:_____ **Pt. Height:**_____

Patient Signature:_____