Lennox & Addington County General Hospital

DIAGNOSTIC IMAGING

# Magnetic Resonance Imaging

**Tel: 613-354-3301 x 4630**

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 (855) 494-1581**

**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 Below)

**Non-Major Reaction** (ie. Hives, Itchy, Nausea/Vomiting)

**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: