Reset

DIAGNOSTIC IMAGING – BREAST MRI

MRI-Breast

QHC Quinte Health Care	MD Name:	Patient Name:
	Signature:	DOB:
	CPSO # :	HCN:
	Date: (d/m/y)	Home Phone:
FAX ALL REQUISITIONS TO:	Copies to:	Cell Phone
613-969-5561	WSIB #:	Address:

A BOOKING WILL NOT BE MADE UNLESS THIS REQUISITION IS COMPLETED IN FULL

Clinical Information: Please choose one.

- ☐ New Biopsy proven invasive lobular carcinoma
- ☐ New Biopsy proven locally advanced carcinoma
- ☐ Implant Assessment
- ☐ Previous invasive lobular carcinoma or locally advanced disease
- ☐ Mammo occult (> 75% density) biopsy proven carcinoma

☐ Pre Menopausal ☐ Post Menopausal LMP:

Safety Questions must be completed

Y	N		Y	N	
☐	☐	Have you ever had metal in your eye? If yes, orbital X-Rays are required pre MRI, Unless previous MRI at QHC after exposure.	☐	☐	Are you claustrophobic? If yes, please see your doctor for a sedative.
☐	☐	Pacemaker or Defibrillator?	☐	☐	Are you currently on dialysis?
☐	☐	Cochlear Implant?	☐	☐	Brain aneurysm clip?
☐	☐	Shrapnel or bullets?	☐	☐	Neurostimulator device?
☐	☐	Any implanted devices?	☐	☐	Pregnant or breastfeeding?

Please specify:_____

Previous Surgeries (please list Sx with dates):

_____

_____

_____

DEPARTMENT USE ONLY

Protocol:

Priority: 1 2 3 4

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

☐ **Sedation** ☐ **Weekday** ☐ **Gfr** ☐ **Orbits** ☐ **Cancer Staging**

Appointment Date & Time:

Notes:

PLEASE ENSURE REQUISITION IS COMPLETE . FAX REQUISITION TO 613-969-5561