Reset

DIAGNOSTIC IMAGING – MAGNETIC RESONANCE IMAGING

MRI

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

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

Exam Requested:

Clinical Information:

☐ ED Patient in Hospital
☐ ED Patient Call Back
☐ Outpatient
☐ Inpatient- Location: ☐

Safety Questions must be completed

Yes	No		Yes	No	
☐	☐	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? Please specify:	☐	☐	Pregnant or breastfeeding?

Pt. Height:_____ Pt. Weight: _____

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 REQUISITON TO 613-969-5561

Rev:2019