


DIAGNOSTIC IMAGING: BREAST MRI

 QHC Quinte Health Care Exceptional Care Inspired by You	<u>ORDERING PHYSICIAN (please print)</u>	OUTPATIENT SERVICES
	Belleville General Hospital 265 Dundas St. E Belleville, ON K8N 5A9 613-969-7400 ext 2802	<u>ORDERING PHYSICIAN (please sign)</u> <u>COPIES TO:</u>
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 – 136 Kilo/ 300 LBS. As a safety precaution, patients exceeding this weight limit cannot be done

<p style="text-align: center;">CLINICAL INFORMATION / HISTORY:</p> <p>Please Choose one of the following:</p> <ol style="list-style-type: none"> 1. New Biopsy proven Invasive Lobular Carcinoma 2. New Biopsy proven locally advanced Carcinoma 3. Previous Invasive Lobular Carcinoma or locally advanced disease 4. Mammo occult (>75% density) biopsy proven carcinoma <p>Pre Menopausal LMP: _____</p> <p>Post Menopausal</p>	<p style="text-align: center;"><u>Patient Safety Screening Questions</u></p> <p style="text-align: right;">Y N</p> <p>Have you ever had metal in your eye?*</p> <p>Any known history of kidney disease?</p> <p>Any known allergy to MRI dye?</p> <p>Are you claustrophobic?*</p> <p>Do you have:</p> <p style="padding-left: 20px;">A pacemaker or defibrillator?</p> <p style="padding-left: 20px;">Brain aneurysm clip?</p> <p style="padding-left: 20px;">Cochlear implant?</p> <p style="padding-left: 20px;">A neurostimulator device?</p> <p style="padding-left: 20px;">Shrapnel or bullets?</p> <p>Is there a chance you could be pregnant?</p> <p>Any implanted devices?</p> <p>Please specify: _____</p>
<p style="text-align: center;">DEPARTMENT USE ONLY</p> <p>Protocol: Breast MRI</p> <p>Priority: 1 2 3 4</p> <p>Tech Notes: _____</p> <p>Time Slots: 2 3 4 5 6</p>	<p>*If yes, orbital X-rays are required pre MRI</p> <p>**If yes, please see your Dr. for a sedative</p> <p>Please list all previous surgeries: _____</p>
<p>Date Requisition Received: _____</p> <p>BOOKING DATE: _____ TIME: _____</p> <p>DATE PHYSICIAN NOTIFIED: _____</p> <p><input type="checkbox"/> CREATININE needed</p> <p><input type="checkbox"/> Insufficient Clinical Data <input type="checkbox"/> MRI not indicated</p> <p>NOTES:</p>	<p>Pt. Weight: _____ Pt. Height: _____</p> <p>Patient Signature: _____</p>