

Magnetic Resonance Imaging (MRI) Requisition



HEALTH CARE

ST. PAUL'S HOSPITAL
1081 Burrard St., Vancouver, BC V6Z 1Y6

Appointments: 604-806-8548
Filing/Reports: 604-806-8006
Fax: 604-806-8437

MR MISS MRS MS PERMANENT ADDRESS		SURNAME		FIRST NAME	
POSTAL CODE	CELL PHONE	HOME PHONE	WORK PHONE		
DATE OF BIRTH (MONTH / DAY / YEAR)			AGE	SEX	
HEALTH CARE #		MSP	WCB	ICBC	OTHER
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TO SCHEDULE AN APPOINTMENT PLEASE FAX OR MAIL COMPLETED REQUISITION TO MRI DEPARTMENT

Appointment Date: _____ **Time:** _____

<p>Infection Concerns? <input type="checkbox"/> YES <input type="checkbox"/> NO Specify: _____</p> <p>Is the Patient Pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Relevant Previous Exams? <input type="checkbox"/> X-Ray Date: _____ Location: _____ <input type="checkbox"/> ULTRASOUND Date: _____ Location: _____ <input type="checkbox"/> CT SCAN Date: _____ Location: _____ <input type="checkbox"/> MRI SCAN Date: _____ Location: _____</p> <p>Renal Function Abnormal? <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL eGFR (preferred): _____ or CREATININE: _____</p> <p>Allergy / Asthma / Hay Fever? Specify: _____</p> <p>Is the Patient Claustrophobic? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Is Sedation Required? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, Please Prescribe Sedation Patient's Weight: _____</p>	<p>Exam Requested</p> <hr/> <p>Tentative Diagnosis</p> <hr/> <p>Relevant History / Reason for Exam (Include any Medications)</p> <hr/> <p>Essential Pre-Examination Information FOR PATIENT SAFETY: EXPLAIN IF "YES." KNOWN IMPLANTED METAL OR DEVICE:</p> <p>CEREBRAL ANEURYSM CLIP <input type="checkbox"/> NO <input type="checkbox"/> YES TYPE: _____</p> <p>CARDIAC PACEMAKER <input type="checkbox"/> NO <input type="checkbox"/> YES _____</p> <p>ARTIFICIAL HEART VALVE <input type="checkbox"/> NO <input type="checkbox"/> YES TYPE: _____</p> <p>NEURO STIMULATOR <input type="checkbox"/> NO <input type="checkbox"/> YES _____</p> <p>MIDDLE EAR PROSTHESIS <input type="checkbox"/> NO <input type="checkbox"/> YES _____</p> <p>ORBITAL FOREIGN BODY <input type="checkbox"/> NO <input type="checkbox"/> YES _____</p> <p>METAL WORKER (at any time) <input type="checkbox"/> NO <input type="checkbox"/> YES _____</p> <p>SHRAPNEL, BULLET <input type="checkbox"/> NO <input type="checkbox"/> YES _____</p> <p>ORTHOPEDIC DEVICE <input type="checkbox"/> NO <input type="checkbox"/> YES _____</p> <p>HARRINGTON ROD <input type="checkbox"/> NO <input type="checkbox"/> YES _____</p> <p>VASCULAR FILTER/STENT <input type="checkbox"/> NO <input type="checkbox"/> YES _____</p> <p>VENOUS ACCESS DEVICE <input type="checkbox"/> NO <input type="checkbox"/> YES _____</p> <p>OTHER <input type="checkbox"/> NO <input type="checkbox"/> YES _____</p>
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Incomplete Requests will be Returned

SIGNATURE OF AUTHORIZING PHYSICIAN M.D. _____ PRAC. NO. _____
PLEASE PRINT NAME

PHONE RESULTS: NO YES PHONE NUMBER: _____ ADDITIONAL COPY OF REPORT TO: _____