DIAGNOSTIC IMAGING - MRI

Huntsville District Memorial Hospital
100 Frank Miller Drive
Huntsville, ON P1H 1H7
T: 705-789-2311 x2242
F: 705-788-1485
Open Monday to Friday
7:15 a.m. to 11:30 p.m. (by appointment only)

Referring Physician: _____
Billing#: _____
Referring Physician Signature: _____
Additional Reports to: _____
Referring Physician Address: _____
Referring Physician Office Phone: _____
Referring Physician Fax: _____
☐ Other Insurance/WSIB: _____

Isolation: ☐ Contact ☐ Droplet/Contact ☐ Airborne

Last Name, First Name:	☐ Male ☐ Female	**Date of Birth:**
Health Card Number:	**Version Code:**	**MRN:**
Address:		
Primary Number:	☐ **Cell** ☐ **Home**	☐ **Work**
Secondary Phone Number:	☐ **Cell** ☐ **Home**	☐ **Work**
Clinical History & Diagnostic Questions: ☐ **Cancer screening, diagnosis or staging?**		**Specific Exam Date?**

EXAM REQUIRED (check all that apply)

Brain	**Angiogram (with Gadolinium)**	**Musculoskeletal (Upper Extremity)**
☐ Brain Routine	☐ Subclavians (Bilateral)	Shoulder ☐ R ☐ L
☐ Brain MS	☐ Renal/Mesenteric	Elbow ☐ R ☐ L
☐ Seizure	☐ Thoracic Outlet	Hand/Wrist (Inflam. Arthritis) ☐ R ☐ L
☐ Brain & MRA Cow	☐ Peripheral Runoff	Wrist ☐ R ☐ L
☐ IAC	☐ Thoracic Aorta ☐ Abdominal Aorta	Thumb/Finger – Specify:
☐ MRV Head	☐ Carotid/Vertebrals ☐ Dissection	
☐ Orbits		**Musculoskeletal (Lower Extremity)**
☐ Sella/Pituitary	**Head and Neck**	Hip ☐ R ☐ L
	Brachial Plexus ☐ Right ☐ Left	Pelvis (Body) ☐ R ☐ L
Spine	☐ Neck (soft tissue)	Hamstring (Proximal) ☐ R ☐ L
☐ Cervical	☐ Parathyroids	Knee ☐ R ☐ L
☐ Thoracic	☐ TMJs	Ankle/Hindfoot ☐ R ☐ L
☐ Lumbar (T11-S2)	☐ Parotids	Achilles Only ☐ R ☐ L
☐ Sacrum/Coccyx (bone)		Forefoot (Osteomyelitis) ☐ R ☐ L
☐ Lumbosacral Plexus (nerves)	**Chest and Breast**	Hindfoot (Osteomyelitis) ☐ R ☐ L
☐ Sacroiliac Joints (sacroiliitis)	☐ Breast mass/follow-up	Forefoot (Inflammatory) ☐ R ☐ L
Complete Spine	☐ Breast Implant	Forefoot Other (e.g. Morton's) ☐ R ☐ L
☐ Cord Compression	☐ Chest Mass	
☐ Metastases	☐ **Cardiac**	**Palpable Lump Work Up (With Markers)**
	*Require ECHO report and cardiology consult note.	Upper Extremity ☐ R ☐ L
Abdomen	**Pelvis**	
☐ Liver	☐ Pelvis	Lower Extremity ☐ R ☐ L
☐ MRCP	☐ Rectal Mass	Specify:
☐ Pancreas & MRCP	☐ Anal Fistula	Body/Other ☐ R ☐ L
☐ Spleen	☐ Testicular Mass	Specify location:
☐ Adrenals	☐ Urethra (Female or Posterior Male)	
☐ Kidneys	**Other Request**	
☐ PCKD (renal size only)	Specify:	

If sedation is required for claustrophobia, please arrange this with your patient. Muskoka Algonquin Healthcare MRI will not dispense sedation. If there is a possibility of history of metal being in your patient's eyes, please arrange for orbit xrays to confirm or exclude any metal currently in the eyes. Have the x-ray report sent with this requisition. This will help ensure that the patient's MRI experience goes smoothly.

MUSKOKA ALGONQUIN HEALTHCARE

Patient Name: _____

Date of Birth: _____

RENAL FUNCTION

☐ No hx of renal disease ☐ Hx of renal disease and not on dialysis (attach eGFR within last 6 months)

☐ Peritoneal dialysis ☐ Hemodialysis (provide schedule, e.g. MWF 14:00) _____

C2N úKŜ ǎl·ŧŜúè 2T è2dzN LJl·úΛŜyúΣ LJfŜl·ǎŜ l·nswer the following questions and provide details where indicated. Incomplete forms will be returned to referring provider.

	YES	NO
Falls Risk? Provide details.	☐	☐
Cerebral Aneurysm clips/coils? (Patients with cerebral aneurysm clips/coils will only be scanned if they have been scanned since implantation at the institution that implanted the clips/coils.)	☐	☐
Cochlear implant? (Patients with some cochlear implants can be scanned safely. Submit make & model of implant for review.)	☐	☐
Endoscopy (gastroscopy or colonoscopy) with biopsy AND clip placement within the past 2 months? Send OR notes.	☐	☐
History of injury involving shrapnel, BB pellets, bullets and/or other metal fragments? Provide details.	☐	☐
History of injury to the eye involving metal/metallic object? Provide details.	☐	☐
Implanted Cardiac Pacemaker?	☐	☐
Implanted Cardioverter Defibrilator (ICD)?	☐	☐
Implanted Hearing Device? (e.g., middle-ear and/or auditory brainstem implants)?	☐	☐
Prior surgery or invasive procedures of any kind? Provide details including date(s).	☐	☐
Surgical implants or devices attached to the body? (e.g., screws, pins, plates, joint replacements, pumps, Freestyle Libre, prostheses, electronic or magnetically-activated implants or devices, surgical clips, coils, stents, wires (pacing, stimulator, etc.)) Provide details.	☐	☐
Does patient have allergy to MRI contrast media? Specify reaction:	☐	☐
Does your patient have special needs? (interpreter, non-ambulatory, etc.)? Specify:	☐	☐