CHATHAM-KENT
Health Alliance

Department of Diagnostic Imaging
80 Grand Ave., W.
Chatham, ON. N7L 1B7
Tel: (519) 352-6401 - Ext. 6530
Fax: (519) 437-6040

Medical Registration #: _____
Name: _____
Surname: Middle First
Date of Birth: _____ (yyyy mm dd)
Address: _____
City: _____ Prov.: _____
Postal Code: _____ Telephone #: _____
Health Card #: _____
WSIB #: _____

REQUEST FOR MRI CONSULTATION

Physician Name: _____
Physician Specialty _____
Address: _____
Postal Code: _____ Phone: _____
Referring Hospital: _____
Inpatient ☐ Outpatient ☐ ED Patient ☐ Clinic ☐
Floor _____ Wheelchair ☐ Stretcher ☐
Copy reports to: _____

Date Received _____ (yyyy mm dd)

Date Booked _____ (yyyy mm dd)

MRI RESTRICTIONS:
No patients with implanted defibrillators.
Most pacemakers and pacemaker leads are also contraindicated.
Maximum allowable weight 350lbs/159 kg

Examination Requested: _____
Clinical History (must be entered). _____

YES	NO	THE FOLLOWING MUST BE COMPLETED BEFORE THE MRI WILL BE BOOKED
		Does the patient have a history of impaired renal function?
		Is the patient currently on dialysis?
		Does the patient have hypertension or diabetes?
		Is the patient over 70 years of age?

If you answered yes to any of the first 4 questions and your patient requires/or may require Gadolinium (MRI Contrast) a recent Creatinine μ mol (<3 months) must be forwarded with the requisition.

		Does the patient have a GI Bleed clip?	Make:	Model:
		Does the patient have an Implanted Stimulator?	Make:	Model:
		Does the patient have an IVC Filter?	Make:	Model:
		Does the patient have a Stent?	Make:	Model:
		Does the patient have a Cerebral Aneurysm Clip/Coil?	Make:	Model:
		Is the patient pregnant? If "Yes" or unclear at time of exam, the study may be cancelled		
		Has the patient had previous surgery in the area of imaging?		
		Patient weight: lb./kg		
		Any previous relevant MRI or CT? If yes where/when:		
		Is the patient claustrophobic or require sedation for their exam? If yes, patient's physician to prescribe medication prn.		
		Has patient ever had metal in his/her eye? If yes, orbit x-ray must be ordered prior to exam.		
		Patient requiring special needs? (hydra lift) If yes, please list:		

Are you requesting a timed follow-up procedure (e.g. 6 month follow-up)? Date requested: _____ (yyyy mm dd)

Priority (circle one)

Not Urgent 10 9 8 7 6 5 4 3 2 1 Urgent

Ordering Physician's Signature (required) _____

****RADIOLOGIST'S USE ONLY**** ☐ 1 slot ☐ 2 slot ☐ 3 slot

PRIORITY 1 2 3 4 T OT SD BC

****INCOMPLETE REQUESTS WILL BE RETURNED-RESULTING IN DELAY/CANCELLATION OF THE PROCEDURE****