MRI Requisition

IMPORTANT: *Fields must be completed to avoid delays in patient processing

PATIENT INFORMATION

LAST NAME*	FIRST NAME*	PERSONAL HEALTH NUMBER*
ADDRESS*	CITY* PROVINCE* POSTAL CODE*	DATE OF BIRTH* YYYY / MM / DD
PRIMARY PHONE*	ALTERNATE PHONE*	EMAIL
HEIGHT (CM)* / WEIGHT (KG)* / SEX	INFECTION CONCERNS ☐ MRSA ☐ C.diff ☐ VRE ☐ Active TB ☐ Other:	INTERPRETER REQUIRED ☐ No ☐ Yes, specify language:
MOBILITY REQUIREMENTS* ☐ Ambulatory ☐ Wheelchair/Walker ☐ Lift/Sling	BILL TO ☐ MSP insured ☐ ICBC ☐ WSBC ☐ Patient ☐ Other:	ICBC/WSBC NUMBER

EXAM INFORMATION AND HISTORY

EXAM REQUESTED (ATTN: General Physicians and Nurse Practitioners: Appropriateness checklist must accompany referrals for lumbar spine, knee, hip, shoulders and heads)*	PREVIOUS SURGERY IN AREA OF EXAM: ☐ No ☐ Yes, specify surgery date
REASON FOR EXAM / RELEVANT CLINICAL HISTORY*	RELEVANT PREVIOUS EXAMS ☐ MRI ☐ CT ☐ X-Ray ☐ Ultrasound ☐ Nuclear Medicine ☐ Angiogram Specify dates and locations

*SAFETY SCREENING (must complete for all MRI exams requested)

Patient pregnant	☐ No ☐ Yes	Cerebral Aneurysm Clip	☐ No ☐ Yes, type:		
Brain Shunt If Yes Type:	☐ No ☐ Yes	Middle Ear Prosthesis	☐ No ☐ Yes, type:		
Neurostimulator	☐ No ☐ Yes	Penile Implant	☐ No ☐ Yes, type:		
Glucose Monitoring Device (Needs to be removed for exam)	☐ No ☐ Yes	Breast Tissue Expander type:	☐ No ☐ Yes (not breast implants),		
Implanted Infusion Pump	☐ No ☐ Yes	Patient claustrophobic	☐ No ☐ Yes, prescribe sedation		
Shrapnel and/or Bullet where:	☐ No ☐ Yes	Cardiac	☐ No ☐ Yes, type: Pacemaker/Defibrillator		
Metallic Orbital Foreign Body Removed?	☐ No ☐ Yes ☐ No ☐ Yes				

*EXAMS REQUIRING CONTRAST

Patient on dialysis	☐ No ☐ Yes
Kidney Disease	☐ No ☐ Yes
Allergies If yes please list:	☐ No ☐ Yes
PICC line / IV problems	☐ No ☐ Yes

If yes to any above, please indicate the most recent eGFR results and the date it was obtained. Current eGFR within 3 months of appointment may be required if contrast is given. **Most MSK, spine, and routine neuro exams do not require contrast.**

eGFR result: Date:

CLINICIAN INFORMATION

REQUESTING CLINICIAN NAME*	MSP BILLING NUMBER*	CLINICIAN PHONE*	CLINICIAN FAX*
COPY REPORT TO (FIRST AND LAST NAME)		MSP BILLING NUMBER	COPY TO FAX NUMBER

INDICATE BOOKING PREFERENCE

☐ SOUTH ISLAND	☐ CENTRAL ISLAND	☐ NORTH ISLAND
☐ Patient Consents to Overnight 22:00pm-6:00am appointment Fax (250) 727-4448 Phone (250) 727-4107	NRGH Fax (250) 716-7725 Phone (250) 755-7628 CDH/WCGH Fax (250) 740-6958 Phone (250) 755-7691 (53073)	CRG Fax (250) 286-7106 Phone (250) 286-7100 (67473) CVH Fax (250) 331-5906 Phone (250) 331-5900 (65472)

PROTOCOL AND PRIORITY (DEPARTMENTAL USE ONLY): ☐ STAT ☐ ASAP ☐ SEMI URGENT ☐ ROUTINE ☐ TIMED: ☐ WITH CONTRAST ☐ WITHOUT CONTRAST