Place Patient Form Label Here

LOWER MAINLAND MRI REQUISITION

* 5 2 1 8 *

Requisition Form

Fax Outpatient Requisition to MRI Central Intake: 1-866-588-6955

DEPARTMENT USE ONLY			
Requisition Received Date:	Time:	Appointment Date:	Time:

IMPORTANT: MRI requests will be assigned to a lower mainland site with the earliest appropriate appointment time unless a preferred site is indicated. Grey highlighted fields must be completed to avoid delays in patient processing.

PATIENT INFORMATION

LAST NAME	FIRST NAME	PERSONAL HEALTH NUMBER
ADDRESS	CITY PROVINCE POST CODE	DATE OF BIRTH YYYY MM DD
PRIMARY PHONE / ALTERNATE PHONE	EMAIL	Patient consents to appointment information being disclosed to them in a text or email message. ☐ Yes, text ☐ Yes, email ☐ No
HEIGHT (CM) / WEIGHT (KG) / SEX	INFECTION CONCERNS ☐ MRSA ☐ C.diff ☐ VRE ☐ Active TB ☐ Other:	INTERPRETER REQUIRED ☐ No ☐ Yes, specify language:
MOBILITY REQUIREMENTS ☐ Ambulance ☐ Wheelchair ☐ Mechanical Lift	BILL TO ☐ MSP Insured ☐ ICBC ☐ WSBC ☐ Patient ☐ Other:	ICBC/WSBC NUMBER

EXAM INFORMATION AND HISTORY

EXAM REQUESTED (Appropriateness checklist must accompany referral for lumbar spine, knee and hip)	PREFERRED MRI SITE (indicating site may results in a longer wait time)
REASON FOR EXAM / RELEVANT CLINICAL HISTORY (Include any relevant medications)	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:	
Internal Electrodes or Wires ☐ No ☐ Yes	Middle Ear Prosthesis ☐ No ☐ Yes, type:	
Neurostimulator ☐ No ☐ Yes	Intravascular Stent/Filter ☐ No ☐ Yes, type:	
Metallic Orbital Foreign Body ☐ No ☐ Yes	Breast Tissue Expander ☐ No ☐ Yes (not breast implants), type:	
Implanted Infusion Pump ☐ No ☐ Yes	Patient claustrophobic ☐ No ☐ Yes, prescribe sedation	
Shrapnel and/or Bullet ☐ No ☐ Yes where:	Cardiac Pacemaker/Defibrillator ☐ No ☐ Yes, type:	

EXAMS REQUIRING CONTRAST

Patient is over 60 ☐ No ☐ Yes	
Diabetes or hypertension ☐ No ☐ Yes	
Severe hepatic disease ☐ No ☐ Yes	
Liver transplant ☐ 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 appointments 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
REQUISITION SUBMISSION DATE YYYY MM DD	COPY REPORT TO (FIRST AND LAST NAME)	MSP BILLING NUMBER	COPY TO FAX NUMBER

TECHNOLOGIST NOTES	**RADIOLOGIST PROTOCOL AND PRIORITY**
	☐ P1 ☐ P2 ☐ P3 ☐ P4 ☐ Specified Date: