Request for MRI Consultation
(Magnetic Resonance Imaging)
HNHB LHIN

Last Name	First Name
HIN/HCN/OHCN/OHIP #	Date of Birth (yyyy/mm/dd)
Address	
City / Province	Postal Code
Phone Number:	Mobile Number:
Gender	Weight (kg) Age

REQUEST TO: **Referral Date:** _____

☐ **Juravinski Hospital & Cancer Centre**
Phone: 905-577-1484
Ext. 41484
Fax: 905-387-8813

☐ **McMaster University Medical Centre & Children's Hospital**
Phone: 905-521-5059
Ext. 75059
Fax: 905-521-5057

☐ **Hamilton General Hospital**
Phone: 905-521-2100
Ext. 46061
Fax: 905-523-6241

☐ **St. Joseph's Healthcare Hamilton**
Phone: 905-521-6074
Fax: 905-521-6166

☐ **Joseph Brant Hospital**
Phone: 905-336-4126
Fax: 905-336-4148

☐ **Brantford General Hospital**
Phone: 519-751-5544
Ext: 2287
Fax: 519-751-5813

☐ **Greater Niagara General**
Phone: 905-378-4647
Fax: 905-358-4911

☐ **St. Catharines Hospital**
Phone: 905-378-4647
Fax: 905-684-6990

Referring Physician: _____ _____ Unit: _____ Phone: _____
(Printed Name) (Signature & Designation)

Hospital/Other Facility: _____ Phone: _____ Fax: _____

Primary Care Physician: _____ _____ _____
(Printed Name) (Phone Number) (Fax)

Send Additional Report to: ☐ Primary Care Physician ☐ Other: _____ _____ _____
(Printed Name) (Phone Number) (Fax)

Patient Routing:
- ☐ Hospital preference: _____
- ☐ Next available appointment at any hospital

Exam Payee:
☐ OHIP ☐ WSIB # _____ ☐ Self ☐ Third Party Specify: _____

Current Patient Location:
☐ Inpatient ☐ Outpatient ☐ Emergency

Language Preferred: ☐ English ☐ French ☐ Other: _____
Interpreter Required? ☐ Yes ☐ No

Exam Requested (be specific):

Clinical Information / Relevant History:

Please answer all of the following questions:
1) Known Renal Disease? **YES/ NO**
2) Known Diabetes? **YES/ NO**

If answer to any of the above question(s) is yes, then provide eGFR/ Creatinine within 3 months
eGFR:_____ mL/min/1.73^2 Date (yyyy/mm/dd): _____
Creatinine:_____ml/min/1.73^2 Date (yyyy/mm/dd)_____

Study (e.g. CT/MRI/Xray)	Date (yyyy/mm/dd)	Location

These Safety Questions must be answered by the patient:

Check Yes or No to all questions:	**YES**	**NO**
1. Have you had a previous MRI?	☐	☐
2. Have you ever had a metallic foreign body in your eye?	☐	☐
If yes, was it removed?	☐	☐
3. Are you pregnant or breastfeeding?	☐	☐
4. Are you claustrophobic requiring sedation?	☐	☐
5. Do you require any physical aids (wheelchair, stretcher, etc.)	☐	☐
6. Do you have any drug allergies? If yes, Please indicate: _____	☐	☐
Do you have any of the following?		
7. Heart pacemaker / defibrillator?	☐	☐
8. Brain aneurysm clip?	☐	☐
9. Spine Neurostimular	☐	☐
10. Body jewelry, piercings, tattoos?	☐	☐
11. Ear implants (excluding hearing aids)?	☐	☐
12. Other implanted device or surgeries?	☐	☐

Details (type of implant or surgery, year of procedure, etc.):
_____
_____

Is this a Pediatric Patient? ☐ Yes ☐ No
Any special considerations (phobias, delayed)?
☐ Sedation ☐ GA (Consult with Anesthesia is required)
☐ Other_____
Details_____

FOR MRI USE ONLY
Reviewed by: _____ _____ Date: _____
(Printed Name) (Signature & Designation) (yyyy/mm/dd)

Priority: 1 2 T2 3 T3 4 T4 Test Date (yyyy/mm/dd): _____ Test Time (hh:mm): _____

Clinical Indication: ☐ Cancer ☐ Breast Screening ☐ Other_____

☐
Protocol: _____ Date Protocol (yyyy/mm/dd): _____

Radiologist - Printed Name: Signature: