LOWER MAINLAND MRI REQUISITION

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. Yellow highlighted 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	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 referrals for lumbar spine, knee and hip)	PREFERRED MRI SITE (indicating a site may result 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:	Patient is over 60 ☐ No ☐ Yes
Internal Electrodes or Wires ☐ No ☐ Yes	Middle Ear Prosthesis ☐ No ☐ Yes, type:	Diabetes or hypertension ☐ No ☐ Yes
Neurostimulator ☐ No ☐ Yes	Intravascular Stent/Filter ☐ No ☐ Yes, type:	Severe hepatic disease ☐ No ☐ Yes
Metallic Orbital Foreign Body ☐ No ☐ Yes	Breast Tissue Expander ☐ No ☐ Yes (not breast implants), type:	Liver transplant ☐ No ☐ Yes
Implanted Infusion Pump ☐ No ☐ Yes	Patient claustrophobic ☐ No ☐ Yes, prescribe sedation	PICC line / IV problems ☐ No ☐ Yes
Shrapnel and/or Bullet ☐ No ☐ Yes where:	Cardiac Pacemaker/Defibrillator ☐ No ☐ Yes, type:	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:

EXAMS REQUIRING CONTRAST

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: