Request for Magnetic Resonance Imaging (MRI) – Quebec patient

Medical Imaging Department

Fax

613-636-6211
613-636-6172

Date of request (yyyy/mm/dd)

Fields marked (*) must be completed to avoid delays in processing the request.

PATIENT INFORMATION

*Name	*First name		*Date of birth (yyyy/mm/dd)
*Civic address	*City	*Province	*Telephone (day)
*Weight	*Height	*Gender	*Telephone (night)
*Health card number – RAMQ	Mobility requirements: ☐ Ambulant ☐ Wheelchair ☐ Stretcher; A lift is required? ☐ Yes ☐ No		

EXAM INFORMATION AND HISTORY

*Examination requested

*HGH's *MRI Referral Decision Support Checklist, Headache in Adults* or *MRI Referral Decision Support Checklist, Low Back Pain in Adults* **MUST** accompany referrals for headache or low back pain.

*Patient history and clinical information (include date and location of relevant exams performed previously including all MRI exams).	*Known allergies?

Request for Date-Specific Exam

Access to MRI services is limited,
and only some date-specific requests will be accepted.

Specific date requested (yyyy/mm/dd) : _____

Please justify medical necessity for this date-specific exam.

Yes	No	*Please check the appropriate box below.
☐	☐	Patient is pregnant or breastfeeding
☐	☐	Patient is on dialysis.
☐	☐	Patient has an allergy to MRI contrast agent.

*Possible MRI Contraindications

Yes	No	
☐	☐	History of possible metal in eye for which medical attention was required
☐	☐	Eye surgery (excluding cataract or laser surgery)
☐	☐	Ear surgery (excluding ear tubes)
☐	☐	Implanted pacemaker, defibrillator, stimulator, pump, electrodes or any other device
☐	☐	Any filters, stents, coils, grafts, shunts, clips or port-a-caths, or any other implants
☐	☐	Aneurysm surgery

If available, provide value and date of most recent eGFR result (within last 6 months).

eGFR level	Date de test (yyyy/mm/dd)

*Please forward operative report, and specify the device information below.

*Device	*Date (yyyy/mm/dd)	*Institution where treatment was received

All of the Hawkesbury and District General Hospital services are offered in English and in French.

REFERRING PHYSICIAN INFORMATION

*Name	*First name	*Signature	
Address	City	Province	Postal code
*Telephone	*Fax	*Billing number	

TRANSMISSION OF A COPY OF THE REPORT

*Name	*First name	*Fax	
Address	City	Province	Postal code

☐ Yes	☐ No		☐ Yes	☐ No	☐ 1m	☐ 3m	☐ 6m		