Request for Magnetic Resonance Imaging (MRI) – Quebec patient

Medical Imaging Department

Fax

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**	***Postal code**
***Weight**	***Height**	***Gender**	***Telephone number(s)**
***Health card number – RAMQ** ***Expiry date**	**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		