Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Imaging Services Department
76 Stuart Street
Kingston, ON K7L 2V7
613.549.6666 Ex.: 2786 or
Fax: 613.548.2410

REQUEST FOR MR CONSULTATION

Date Received _____ (YYYY/MM/DD) Date Booked _____ (YYYY/MM/DD)

INPATIENT ☐ Service: _____

Floor _____ Room # _____ ER _____

☐ Stretcher ☐ Wheelchair ☐ Walk ☐ O_2

Isolation: ☐ No ☐ Yes/type _____

Urgency score (circle) 1 - EMERGENCY within 24 hours
2 - Within 48 hours
3 - Within 10 days
4 - Beyond 10 days

Urgency score of 1 requires consultation with MRI physician

OUTPATIENT ☐

CR#: _____ ☐ Female ☐ Male

Surname: _____

First Name: _____

Date of Birth: _____

Address: _____

Phone #: (H) _____ (W) _____

Health Card # _____

INCOMPLETE or ILLEGIBLE requisitions will be returned and will DELAY Study

Procedure requested: _____ Patient Weight _____

Indication for procedure: _____

_____

Reason for scan: ☐ Diagnosis ☐ Breast Cancer Screening ☐ Surgical Planning ☐ Cancer Staging/Dx ☐ Follow Up

Previous Relevant Imaging (where?when?) _____
Previous Relevant Surgery (type): _____ When _____

Patients may require eGFR in accordance with CAR guidelines **(listed on mandatory screening form attached)**
Please specify reason for eGFR requirement as per CAR guidelines: _____

eGFR – Date Drawn (YYYY/MM/DD): _____ (within 60 days of MRI) Results: _____

	Y	N
Claustrophobic		
Require sedation/anaesthesia		
Anesthesia Notified		
Cardiac pacemaker & model		
Prosthetic heart valve		
Metallic foreign body		
Pregnant		
Vascular access port/catheter		
Previous Gadolinium		
Surgical aneurysm clip		
Previous Eye Injury/foreign body		
Recent Caval Filter/Stent (<6 months)		

Ordering Physician Signature: _____

Printed Name & First Initial: _____

Ordering Physician phone/pager #: _____

Attending Physician: _____

Copy Report to: _____
(Please print name and first initial)

Date requisition complete _____
yyyy/mm/dd

Please list any Implants: (or attach full info) _____ Make: _____
Model _____ Date Inserted _____ Where _____

FOR RADIOLOGIST USE ONLY: Priority 1 2 3 4 Gadolinium: Yes ☐ No ☐ Dose _____

PROTOCOL:

Approval: Signature: _____ Date: _____
yyyy/mm/dd