Kingston General Hospital
Imaging Services Department
76 Stuart Street
Kingston, ON K7L 2V7
613.549.6666X2786 or 613.548.6096
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

Kingston
General Hospital

MRI SCREENING FORM

Patient Weight _____ **Patient Height** _____ **Allergies** _____

To ensure patient safety, this form **MUST BE COMPLETED**.

Patients requiring eGFR prior to gadolinium injections (CAR Guidelines)

Impaired Renal Function for any reason	Age 60 or over	Previous MI	Kidney Disease
Peripheral Vascular Disease	Organ transplant	Stroke	
Chemotherapy for Malignancy	High Blood Pressure	Diabetes	

YES✓	NO✓	
		Have you had a previous MRI?
		Have you ever been a metal worker, grinder or welder?
		Have you ever had a metal foreign body in or around the eyes or been exposed to metal dust of slivers?
		Are you pregnant or breast-feeding?
		Are you claustrophobic?
		Are you connected to any supportive medical device?
		Do you have any of the following in place:
		Cardiac Pacemaker, ICD, or Leads
		Heart Valve Prosthesis
		Aneurysm Clip(s)
		Intraventricular Shunt
		Orbital Implants
		Neurostimulator, Bone Growth Stimulator, Biostimulator
		Implanted Drug Infusion Device/Insulin Pump
		Inner Ear Implants – Cochlear, Stapes, Aids
		Joint Replacements/Prosthesis
		Coil, filter or Stent (intravascular)
		Genital Prosthesis/Devices (Penile, diaphragm, IUD)
		Surgical Rods/Wires/Plates
		Vascular access port (PICC line, Swan Ganz, Port-a-cath)
		Dentures, Braces
		Tattoos, Permanent Cosmetics
		Body Piercing, Body Jewellery
		Medication Patches
		Shrapnel/Bullets
		Other Surgeries

I have been informed how the MR examination is performed and that an injection of Gadolinium may be used to enhance the study. I have answered the questions and agree to the procedure as described.

Verbal Consent for IV Gadolinium _____

_____ _____
Patient/Guardian Signature Date (yyyy/mm/dd)

_____ _____
Tech/Witness Signature Date (yyyy/mm/dd)

Clinical History: _____

_____

_____