

**Medical Imaging Department  
MAGNETIC RESONANCE  
IMAGING (MRI) REQUISITION**

<b>Appt. Date:</b>	<b>Appt. Time:</b>	<b>Initial</b>

**FORM SF0060 Page 1 of 1 Rev. 12/2018**

Patient LABEL / Identification Area

**EXAMINATION(S) REQUESTED:**

**CLINICAL HISTORY: (PLEASE ATTACH ALL REPORTS)**

**RENAL FUNCTION SCREENING FOR PATIENTS REQUIRING INTRAVASCULAR CONTRAST MEDIA**

Complete the following section for patients requiring intravascular MRI contrast media (select all applicable risk factors). Creatinine/eGFR is required for patients with one or more risk factors.

- |   |   |
|---|---|
| <input type="checkbox"/> History of renal disease (kidney transplant, single kidney, renal surgery, dialysis/chronic renal failure) | <input type="checkbox"/> Risk for acute kidney injury (e.g. Hypotension with systolic BP < 90mmHg, dehydration, sepsis) |
| <input type="checkbox"/> Hypertension requiring two or more medication  | <input type="checkbox"/> Type 1 or Type 2 diabetes <input type="checkbox"/> None  |

Creatinine Result : $\mu\text{mol/L}$	Result acceptable within 90 days if eGFR is $\geq 40\text{mL/min/1.73 m}^2$ Result acceptable within 30 days if eGFR is $< 40\text{mL/min/1.73 m}^2$
eGFR Result/Calculation: $\text{ml/min/1.73 m}^2$	
Date of Result (include copy):	

Patient Height \_\_\_\_\_ inches/cm Patient Weight \_\_\_\_\_ lbs/kg **(MANDATORY)**

Does the patient have any of the following :	Y	N	List prior surgery/implants
1. Pacemaker/ICD (or transvenous wires) - <b>contraindication at NYGH</b>			
2. Intracranial aneurysm clip? (provide details)			
3. Any type of eye or ear implant surgery? (provide details)			
4. Any type of heart surgery? (cardiac valve/vascular or coronary artery stent) Please provide details in space to the right.			
5. Any type of mechanical/magnetic implant, stimulator, or insulin pump?			
6. Eye injury (with metal) and sought medical attention? If "Y" orbit x-ray			
7. Shrapnel or bullet Injury (where?)			
8. Medicated patch? Type?			
9. Is there a chance of pregnancy? LMP:			
10. Claustrophobia? (referring MD is responsible for sedation)			

**ALLERGY INFORMATION**

Does patient have an allergy to MRI Contrast?  YES  NO  
If yes describe the reaction \_\_\_\_\_

- **By the use and submission of this requisition, the MRP is acknowledging that NYGH can use telephone, text message, or email communication to schedule and coordinate appointments.**
- **Interpreter recommended for non-English speaking patients**

PHYSICIAN'S SIGNATURE

**REQUESTING PROVIDER INFORMATION**

Name \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_  
OHIP Billing Number: \_\_\_\_\_ CPSO # \_\_\_\_\_