NORTH YORK GENERAL

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Medical Imaging Department
MAGNETIC RESONANCE IMAGING (MRI) REQUISITION

Appt. Date:	Appt. Time:	Initial

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.

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

Creatinine Result : μmol/L	Result acceptable within 90 days if eGFR is ≥ 40mL/min/1.73 m^2
eGFR Result/Calculation: ml/min/1.73 m^2	Result acceptable within 30 days if eGFR is < 40mL/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) - **contraindication at NYGH**			
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 #_____