NORTH YORK GENERAL
Making a World of Difference

Medical Imaging Department
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MAGNETIC RESONANCE IMAGING (MRI) REQUISITION

FORM SF0060 **Page 1 of 1** **Rev. 08/2023**

Patient LABEL / Identification Area

Patient Name:_____ **Patient Email Address:**_____

By providing your patient's email address you are giving permission to contact the patient via email with appointment time and information

INCOMPLETE FORMS WILL BE RETURNED AND NOT BE PROCESSED

EXAMINATION(S) REQUESTED

_____

CLINICAL HISTORY:

FOR OFFICE USE ONLY

GE ❒ Siemens ❒ Either ❒
FBO ❒ NPO ❒ Fleet ❒ GAD ❒
9-15 ❒ 8-22 ❒ WkDy ❒ Wknd ❒
Time: 20 ❒ 30 ❒ 45 ❒ 60 ❒ 75 ❒
Protocol:

Priority: 1 ❒ 2 ❒ 3 ❒ 4 ❒

RENAL FUNCTION SCREENING QUESTIONNAIRE FOR PATIENTS REQUIRING GADOLINIUM BASED CONTRAST MEDIA

- ❒ Does patient have a history of severe chronic kidney disease (eGFR < 30 ml/min/1.72 m2)?
- ❒ Does patient have a history of dialysis-dependent kidney disease?
- ❒ None of the above

Does the Patient have any of the following (Provide Details):	Y	N
Pacemaker/ICD (or transverse wires)?		
Intracranial aneurysm clip?		
Any type of eye or ear implant?		
Any type of heart surgery (cardiac valve or coronary artery stent)?		
Any type of mechanical/magnetic implant, stimulator or insulin pump?		
Eye injury (with metal), and/or shrapnel or bullet injury? (x-rays required)?		
Medicated Patch? Type?		
Is there any chance of pregnancy? LMP?		
Claustrophobia? (referring MD responsible for sedation if required)		

Patient Height:_____ **inches/cm** **Weight:**_____ **lbs/kg**

List Prior surgery/implants:

Provide details (make/model/date) of any implanted metallic/magnetic device

Tech Signature:_____ **Date:**_____

Patient Signature:_____ **Date:**_____

ALLERGY, PRIOR EXAMS AND APPOINTMENT INFORMATION

Allergy to MRI Contrast (Gadolinium)? ☐ YES ☐ NO
If YES, describe reaction:_____

Reports from relevant prior exams must be included with requisition

If patient is not English speaking, please ask patient to have a translator accompany them for their exam

Certain implants may be a contraindication to MRI and will be evaluated on a case by case basis

REQUESTING PROVIDER

Address:_____

City:_____ Postal Code:_____

Telephone Number:_____

Fax Number:_____

Billing Number:_____

Copy to:_____

DATE/TIME	SIGNATURE (REQUESTING PROVIDER)	PRINT NAME
DD / Month / YYYY : h		

Revised by Medical Imaging Manager 04/2023