Request for MRI Consultation
(Magnetic Resonance Imaging)
HNHB LHIN

Last Name	First Name	
HIN/HCN/OHCN/OHIP #	Date of Birth (yyyy/mm/dd)	
Address		
City / Province	Postal Code	
Phone Number:	Mobile Number:	
Gender	Weight (kg)	Age

REQUEST TO: **Referral Date:** ____________________

☐ **Brantford General Hospital**
Phone: 519-751-5544
Ext: 2287
Fax: 519-751-5813

☐ **Greater Niagara General**
Phone: 905-378-4647
Fax: 905-358-4911

☐ **Hamilton General Hospital**
Phone: 905-521-2100
Ext: 46061
Fax: 905-523-6241

☐ **Joseph Brant Hospital**
Phone: 905-336-4126
Fax: 905-336-4148

☐ **Juravinski Hospital & Cancer Centre (Hamilton)**
Phone: 905-557-1484
Ext: 41484
Fax: 905-387-8813

☐ **McMaster University Medical Centre & Children's Hospital (Hamilton)**
Phone: 905-521-5059
Ext: 75059
Fax: 905-521-5057

☐ **St. Catharines Hospital**
Phone: 905-378-4647
Fax: 905-684-6990

☐ **St. Joseph's Healthcare (Hamilton)**
Phone: 905-521-6074
Fax: 905-521-6166

Referring Physician: ____________________ (Printed Name) ____________________ (Signature & Designation) Unit: __________ Phone: __________

Hospital/Other Facility: ____________________ Phone: ____________________ Fax: ____________________

Primary Care Physician: ____________________ Phone: ____________________ Fax: ____________________

Send Additional Report to: ☐ Primary Care Physician ☐ Other: ____________________ (Printed Name) __________ (Phone Number) __________ (Fax)

Exam Payee:
☐ OHIP ☐ WSIB # __________ ☐ Self ☐ Third Party Specify: __________

Patient Routing:
☐ Hospital preference: ____________________
☐ Next available appointment at any hospital

Exam Requested (be specific):

Current Patient Location:
☐ Inpatient ☐ Outpatient ☐ Emergency

Language Preferred: ☐ English ☐ French ☐ Other: __________
Interpreter Required? ☐ Yes ☐ No

Clinical Information / Relevant History:

Please answer all of the following questions:

1) Known Renal Disease? **YES / NO**
2) Known Diabetes? **YES / NO**
3) On Metformin? **YES / NO**

If the answer to any of the above question(s) is yes, then please provide eGFR / Creatinine results within 3 months:

eGFR:________ ml/min/1.73² Date:________________ (yyyy/mm/dd)

Creatinine:________ ml/min/1.73 Date:________________ (yyyy/mm/dd)

Relevant tests to date:

Study (e.g. CT/MRI/Xray)	Date (yyyy/mm/dd)	Location

These Safety Questions must be answered by the patient:
Check Yes or No to all questions:

		YES	NO
1.	Have you had a previous MRI?	☐	☐
2.	Have you ever had a metallic foreign body in your eye?	☐	☐
	If yes, was it removed?	☐	☐
3.	Are you pregnant or breastfeeding?	☐	☐
4.	Are you claustrophobic requiring sedation?	☐	☐
5.	Do you require any physical aids (wheelchair, stretcher, etc.)	☐	☐
6.	Do you have any drug allergies? If yes, Please indicate: ______________	☐	☐

Do you have any of the following?

		YES	NO
7.	Heart pacemaker / defibrillator?	☐	☐
8.	Brain aneurysm clip?	☐	☐
9.	Spine Neurostimular	☐	☐
10.	Body jewelry, piercings, tattoos?	☐	☐
11.	Ear implants (excluding hearing aids)?	☐	☐
12.	**Other implanted device or surgeries?**	☐	☐

Details (type of implant or surgery, year of procedure, etc.):
____

Additional Information:

FOR MRI USE ONLY

Reviewed by: ____________________ (Printed Name) ____________________ (Signature & Designation) Date: ____________________ (yyyy/mm/dd)

Priority: **1 2 T2 3 T3 4 T4** Test Date: ____________________ (yyyy/mm/dd) Test Time: ____________________ (hh:mm)

Clinical Indication: ☐ Cancer ☐ Other: ____________________

Protocol: ____________________________________ Date Protocolled: (yyyy/mm/dd) Radiologist (printed): ____________________

Additional Comments: ____________________________________ Signature: ____________________