

DEPARTMENT USE ONLY			
Requisition Received Date:	Time:	Appointment Date:	Time:

IMPORTANT: MRI requests will be assigned to a lower mainland site with the earliest appropriate appointment time unless a preferred site is indicated. Yellow highlighted fields must be completed to avoid delays in patient processing.

PATIENT INFORMATION					
LAST NAME		FIRST NAME		PERSONAL HEALTH NUMBER	
ADDRESS			CITY	PROVINCE	POSTAL CODE
				DATE OF BIRTH	
				YYYY MM DD	
PRIMARY PHONE		ALTERNATE PHONE		EMAIL	
				Patient consents to appointment information being disclosed to them in a text or email message <input type="checkbox"/> Yes, text <input type="checkbox"/> Yes, email <input type="checkbox"/> No	
HEIGHT (CM)	WEIGHT (KG)	SEX	INFECTION CONCERNS		INTERPRETER REQUIRED
			<input type="checkbox"/> VRE <input type="checkbox"/> Active TB <input type="checkbox"/> MRSA <input type="checkbox"/> C.diff <input type="checkbox"/> Other:		<input type="checkbox"/> No <input type="checkbox"/> Yes, specify language:
MOBILITY REQUIREMENTS			BILL TO		ICBC/WSBC NUMBER
<input type="checkbox"/> Ambulance <input type="checkbox"/> Wheelchair <input type="checkbox"/> Mechanical Lift			<input type="checkbox"/> MSP insured <input type="checkbox"/> ICBC <input type="checkbox"/> WSBC <input type="checkbox"/> Patient <input type="checkbox"/> Other:		

EXAM INFORMATION AND HISTORY	
EXAM REQUESTED (Appropriateness checklist <u>must</u> accompany referrals for lumbar spine, knee and hip)	PREFERRED MRI SITE (indicating a site may result in a longer wait time)
REASON FOR EXAM / RELEVANT CLINICAL HISTORY (include any relevant medications)	RELEVANT PREVIOUS EXAMS
	<input type="checkbox"/> MRI <input type="checkbox"/> CT <input type="checkbox"/> X-Ray <input type="checkbox"/> Ultrasound <input type="checkbox"/> Nuclear Medicine <input type="checkbox"/> Angiogram Specify dates and locations

SAFETY SCREENING (must complete for all MRI exams requested)			EXAMS REQUIRING CONTRAST			
Patient pregnant	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cerebral Aneurysm Clip	<input type="checkbox"/> No <input type="checkbox"/> Yes, type:	Patient is over 60		<input type="checkbox"/> No <input type="checkbox"/> Yes
Internal Electrodes or Wires	<input type="checkbox"/> No <input type="checkbox"/> Yes	Middle Ear Prosthesis	<input type="checkbox"/> No <input type="checkbox"/> Yes, type:	Diabetes or hypertension		<input type="checkbox"/> No <input type="checkbox"/> Yes
Neurostimulator	<input type="checkbox"/> No <input type="checkbox"/> Yes	Intravascular Stent/Filter	<input type="checkbox"/> No <input type="checkbox"/> Yes, type:	Severe hepatic disease		<input type="checkbox"/> No <input type="checkbox"/> Yes
Metallic Orbital Foreign Body	<input type="checkbox"/> No <input type="checkbox"/> Yes	Breast Tissue Expander	<input type="checkbox"/> No <input type="checkbox"/> Yes (not breast implants), type:	Liver transplant		<input type="checkbox"/> No <input type="checkbox"/> Yes
Implanted Infusion Pump	<input type="checkbox"/> No <input type="checkbox"/> Yes	Patient claustrophobic	<input type="checkbox"/> No <input type="checkbox"/> Yes, prescribe sedation	PICC line / IV problems		<input type="checkbox"/> No <input type="checkbox"/> Yes
Shrapnel and/or Bullet	<input type="checkbox"/> No <input type="checkbox"/> Yes where:	Cardiac Pacemaker/Defibrillator	<input type="checkbox"/> No <input type="checkbox"/> Yes, type:	If yes to any above, please indicate the most recent eGFR results and the date it was obtained. Current eGFR within 3 months of appointment may be required if contrast is given. Most MSK, spine, and routine neuro exams do not require contrast.		
			eGFR result: _____ Date: _____			

CLINICIAN INFORMATION			
REQUESTING CLINICIAN NAME		MSP BILLING NUMBER	
REQUISITION SUBMISSION DATE		COPY REPORT TO (FIRST AND LAST NAME)	
YYYY MM DD			
		MSP BILLING NUMBER	
		COPY TO FAX NUMBER	

TECHNOLOGIST NOTES	RADIOLOGIST PROTOCOL AND PRIORITY
	<input type="checkbox"/> P1 <input type="checkbox"/> P2 <input type="checkbox"/> P3 <input type="checkbox"/> P4 <input type="checkbox"/> Specified Date: