Hôpital général de la baie Georgienne
GEORGIAN BAY General Hospital

Appointment:

Date:_____

Time:_____

Request For MRI Consultation

Department of Diagnostic Imaging
Tel. (705) 526-1300 Ext. 5090 Fax. (705) 526-7837

Name: _____Gender: □M □F
Address:_____
City:_____ Postal Code:_____
Health Card#:_____
Date of Birth (DD/MM/YYYY):_____
Home #: _____ Cell #: _____

Please allow 1 week to receive notification of appointment

Area to be examined (**be specific**):

Clinical Indication (**provide previous imaging reports**):

Are you requesting a timed follow-up procedure (e.g., 6 month follow-up)? If yes, date requested (DD/MM/YYY):_____

Medical History Assessment:
Dialysis □ Yes □ No

Patient Weight: _____**Patient Height**: _____
Ambulation:
□Walk □Wheelchair □ Stretcher □MEDICAL LIFT

Referring Physician (please print): _____
Address:_____
_____
Tel #: _____Fax #: _____

Physician Signature: _____

To be completed by the referring physician with the patient:
Inaccurate information can result in appointment cancellation the day of exam

Indicate if the patient has the following:	**Yes**	**No**		**Yes**	**No**
Previous reaction to ***MRI*** contrast? *If yes, describe reaction type*:_____			Coils, Filters, or Stents*? If yes, provide the location in the body:*_____		
Claustrophobia? ***If yes, physician to prescribe sedation.***			Neurostimulation System/Other Stimulation Device? (*past or present*) Type:_____		
Have you ever had metal go into your eye that was not removed by a Doctor? ***(If yes, attach Orbit X-ray report)***			Spinal Surgery? *Level of Sx?*_____*Date:*_____		
Any metallic fragment or foreign body? (shrapnel, bullets)			IUD? Type:_____		
Currently pregnant?			Programmable shunt?		
Pacemaker/Defibrillator/ICD**?** *(past or present)* ****Contraindication at GBGH****			Breast Tissue expander? Type:_____		
Prosthetic Heart Valve, Cardiac Closure or Occluder Device? Type:_____			Drug Infusion Pump or Glucose monitor?		
Cerebral Aneurysm Clips?			Any type of prosthesis? (eye, penile, etc.) *If yes, explain*:_____		
Cochlear (ear) implant?			Any other metallic, magnetic or electronic implant? *If yes, explain:*_____		

List <u>all</u> previous surgeries and implants:

For any implants, provide OR reports/records with Make and Model # so we may confirm MRI compatibility. ****Failure to do so may delay booking**

To be done at appointment:
Patient/SDM Signature:_____Technologist:_____Date:_____

For Radiologist use ONLY:

□P1 □P2 □P3 □P4 □T_____

Protocol:

□ Cancer Stage/Diagnosis □ Breast Cancer Screen □ Other

For Booking use ONLY:

□20 □30 □40 □45 □60 □75
□ GAD
□ BUSCOPAN
□ BOOKING TIME_____
□ BOOKING CODE_____