

Bluewater Health

Department of Diagnostic Imaging

89 Norman Street
Sarnia, Ontario N7T 6S3
Ph: 519-464-4491 Fax: 519-464-4455

ED Out Pt In Pr

Patient Name patName

Address patAddressLabel

Postal Code patPostalCode

Phone: Home ...ePhone.default Work ...essPhone.default

D.O.B. patBirthdate.default Sex M F

Health Card Number patHN VC ...Code

Request for Magnetic Resonance Imaging

Allergies: patALLR

To MRI Suite Via

Walking Ambulance Chair Stretcher

Incomplete Requests Will Be Returned resulting in a delay of this procedure.

Area to be Examined (Please be specific)

Pertinent History, Clinical and Imaging Findings: If imaging not performed at Bluewater Health, send copies of reports.

F/U ED

F/U Other

Does the Patient Have Any of the Following Contra-indications

- | | | |
|---|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No Hearing Aid | <input type="checkbox"/> Yes <input type="checkbox"/> No Penile Implant |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cochlear Implant | <input type="checkbox"/> Yes <input type="checkbox"/> No IUD | <input type="checkbox"/> Yes <input type="checkbox"/> No Neurostimulator |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Orthopedic Plate/Pin/Screw | <input type="checkbox"/> Yes <input type="checkbox"/> No Pregnancy/Breast Feeding | <input type="checkbox"/> Yes <input type="checkbox"/> No Infusion Pump |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Prosthesis | <input type="checkbox"/> Yes <input type="checkbox"/> No Dentures/Braces | <input type="checkbox"/> Yes <input type="checkbox"/> No Medication Patches |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tattoos/Tattooed Eye Liner | <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient claustrophobic? | <input type="checkbox"/> Yes <input type="checkbox"/> No Shrapnel/Bullets/Pellets
Where? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cerebral Aneurysm Clip | <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Heart Valve | |
| Make/Model: | Make/Model: | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Other Implants/metal | <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient require an oral sedative prescribed by the referring Physician? | |
| Specify: | <input type="checkbox"/> Yes <input type="checkbox"/> No Can the patient lie motionless on their back for 1 hour? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient ever been a grinder / metal worker / welder and had an eye injury / metal in / around eye? | | |

Previous surgeries (including back) _____

Date of Lab Work Creatinine Level umol/L $\left(\begin{matrix} \text{Adult} \\ \text{M } 57-113 \\ \text{F } 39-88 \end{matrix} \right)$ estimated GFR umi/min/1.73m (>90) Weight Kg

Ordering Physician Signature: _____

Date _____

patFam.fullName

Family Physician

Copy to Physician

For Imaging Department use only

G # _____

Appointment Date _____ at _____ hrs.



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