Brockville General Hospital

MRI REQUISITION

PLEASE FAX COMPLETED REQ TO (855) 564-1890

As of August 2025

DIAGNOSTIC IMAGING USE ONLY

Requisition Received Date: Time	Appointment Date Time

PATIENT INFORMATION

Last Name	First Name	Date of Birth YYYY MM DD
Address	City	Postal Code
Phone	E-mail Address	Health Card Number / Version Code

CLINICAL INFORMATION

MRI REQUESTED:

REASON FOR EXAM/RELEVANT CLINICAL HISTORY:

SAFETY SCREENING (MUST COMPLETE FOR ALL MRI EXAMS REQUESTED)

Patient claustrophobic	☐ Y ☐ N	Eye injury, metal worker	☐ Y ☐ N	Patient over 60	☐ Y ☐ N
Pacemaker/defibrillator (even past) heart surgery	☐ Y ☐ N	Prosthesis or metal in body	☐ Y ☐ N	Diabetes or hypertension	☐ Y ☐ N
Cerebral aneurysm clip	☐ Y ☐ N	Ear or eye implants	☐ Y ☐ N	Severe hepatic disease	☐ Y ☐ N
Coil ,filter, stent, graft, clip, wires	☐ Y ☐ N	Electronic pump, sensor	☐ Y ☐ N	Liver transplant	☐ Y ☐ N
Electronic stimulator	☐ Y ☐ N	Shunt	☐ Y ☐ N	PICC line/IV problems	☐ Y ☐ N
Shrapnel, bullets, BB, pellets	☐ Y ☐ N	Patient pregnant?	☐ Y ☐ N		
Colonoscopy last 6 weeks	☐ Y ☐ N				

CONTRAST SCREENING

CLINICIAN INFORMATION

Requesting Clinician Name (PRINT First and Last Name)	Clinician Fax Number
Clinician Signature	Clinician Phone Number

REQUISITIONS WITHOUT A LEGIBLE NAME, SIGNATURE AND FAX NUMBER WILL BE RETURNED, WHICH MAY CAUSE DELAYS IN PATIENT CARE

Copy Report to (PRINT First and Last Name)	Copy to Fax Number

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Relevant Previous Exam

☐ MRI ☐ **CT** ☐ US

☐ Angio ☐ Nuc Med ☐ X-ray

Dates and Locations:

eGFR: _____

Technologist Notes

Radiologist Protocol and Priority

☐ P1 ☐ P2 ☐ P3 ☐ P4 Special Date: _____/_____/_____ YYYY/MM/DD

GAD

☐ **Yes** ☐ **No**

Location: brockvillegeneralhospital.ca/Patient Care/Patient Referral Forms and Requisitions/Diagnostic Imaging/MRI