Brockville General Hospital

75 Charles Street, Brockville, Ontario
Tel:: 613-345-5649 Ext: 51149

MRI REQUISITION
FAX TO: 613-345-8324

DEPARTMENT USE ONLY			
Requisition Received Date:	Time	Appointment Date	Time

PATIENT INFORMATION

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

CLINICAL INFORMATION

MRI REQUESTED:

REASON FOR EXAM/RELEVANT CLINICAL HISTORY:

SAFETY SCREENING (MUST COMPLETE FOR ALL MRI EXAMS REQUESTED)						CONTRAST SCREENING		
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 in last 6 weeks	☐ Y	☐ N						

Other Relevant Information:

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

DEPARTMENT USE ONLY		
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: ______________________________	GAD ☐ Y ☐ N