northern health
the northern way of caring

All sites and facilities

Magnetic Resonance Imaging (MRI) Requisition

Last Name:
First Name (Preferred Name):
Encounter number: NH Number: Chart Created: Y/N
Date of Birth: Gender: Age: Encounter Type:
Responsibility for Payment: PHN:
Primary Care Physician/Attending Physician:
PATIENT LABEL

Department Use Only Requisition Received Date: Time:	Appointment Date: Time:

Important: "*" 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*:	Height (cm)*: Weight (kg)*: Gender:	Interpreter Required: ☐ No ☐ Yes, specify language:

☐ _____(Name of delegate)_____ can book this appointment for the patient

Mobility Requirements: ☐ Ambulance ☐ Wheelchair ☐ Mechanical Lift

Bill To: ☐ MSP Insured ☐ ICBC ☐ WSBC ☐ Patient ☐ Other: _____ | ICBC/WSBC Number

Infection Concerns: ☐ VRE ☐ Active TB ☐ MRSA ☐ C.diff ☐ Other:

Isolation precautions: ☐ Outpatient ☐ Inpatient

Ordering clinician Timeframe Request: (Note: Medical Imaging department will review with the relevant clinical information provided using MoH guidelines to determine the priority for scheduling the patient.)

MI reviewed Priority P _____ Initials _____

☐ P1: within 24 hours ☐ P2: 2 to 7 days ☐ P3: 8 to 30 days ☐ P4: 31 to 60 days ☐ P5: specific date/follow up: _____

Exam Information and History

Exam Requested (Appropriateness checklist **must** accompany referrals for lumbar spine, knee and hip)* - 10-210-5048 (Regional) 11-210-5048 (PG)	Preferred MRI Site: ☐ Fort St John Fax: (250) 261-7637 ☐ Terrace Fax: (250) 638-4077 ☐ Prince George Fax: (250) 565-5877

Reason for Exam/Relevant Clinical History (include any relevant medications)*

Relevant Previous Exams: ☐ MRI ☐ CT ☐ X-Ray ☐ Ultrasound ☐ Nuclear Medicine ☐ Angiogram
Specify dates and locations:

Safety Screening (must complete for all MRI exams requested)

Patient Pregnant*	☐ No ☐ Yes	Middle Ear Prosthesis* type:	☐ No ☐ Yes	Patient is over 60	☐ No ☐ Yes
Internal Electrodes or Wires	☐ No ☐ Yes	Intravascular Stent/Filter* type:	☐ No ☐ Yes	Diabetes or hypertension	☐ No ☐ Yes
Neurostimulator*	☐ No ☐ Yes	Breast Tissue Expander* (not breast implants) type:	☐ No ☐ Yes	Severe hepatic disease	☐ No ☐ Yes
Previous Metallic Orbital Foreign Body*?	☐ No ☐ Yes	Cardiac Pacemaker/Defibrillator*/ Artificial Valve type:	☐ No ☐ Yes	Liver Transplant	☐ No ☐ Yes
Removed?	☐ No ☐ Yes	Implants* what:	☐ No ☐ Yes	PICC Line/IV Problems	☐ No ☐ Yes
Implanted Infusion Pump*	☐ No ☐ Yes	Patient Claustrophobic* prescribe sedation	☐ No ☐ Yes	If yes to any of these, 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.**	
Shrapnel and/or Bullet* Where:	☐ No ☐ Yes	If yes, physician to provide sedation prescription		eGFR result: Date:	
Metal Worker*	☐ No ☐ Yes				
Cerebral Aneurysm Coil or Clip* Make and Model type:	☐ No ☐ Yes				

Clinical Information

Exam requested*: _____ _____ _____ Previous relevant exams: _____ Previous centre: _____	Ordering clinician's name (print)*: _____ MSP #*: _____ Signature: _____ Copies to*: _____ Phone #*: _____ ☐ Urgent report requested

Prescription required for sedation prior to exam

Protocol Notes

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MEDICAL IMAGING PRIORITIZATION AND COMMUNICATION

To be completed by Medical Imaging personnel:

☐ Radiologist required
Notes for booking staff:

To be completed by booking personnel:

Attempts to book:
1.

2.

3.

Notes:

Appointment date: _____ Time: _____

Place flashcard label here