northern health
the northern way of caring

All Sites and Facilities

Magnetic Resonance Imaging (MRI) Requisition

Last Name:
First Name (Preferred Name):
Encounter #: NH #: Chart Created: ☐ Yes ☐ No
DOB: 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:

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

Mobility Requirements: ☐ Ambulance ☐ Wheelchair ☐ Mechanical Lift ☐ Walk ☐ Stretcher ☐ Bed ☐ Bariatric

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

☐ Outpatient ☐ Inpatient ☐ ER ☐ ICU ☐ Other:

Ordering clinician timeframe request: (**Note:** Medical Imaging department will review with the relevant clinical information provided using BC guidelines to determine the priority for scheduling the patient.)
☐ P1: within 24 hours ☐ P2: 2 to 7 days ☐ P3: 8 to 30 days ☐ P4: 31 to 60 days ☐ P5: specific date/follow up: _____

Preferred MRI Site: ☐ Fort St John Fax: (250) 261-7637 ☐ Terrace Fax: (250) 638-4077 ☐ Prince George Fax: (250) 565-5877

*Safety Screening (must complete for all MRI exams requested)

Patient Pregnant	☐ No ☐ Yes	Intravascular Stent/Filter*:	☐ No ☐ Yes
Internal Electrodes or Wires	☐ No ☐ Yes	Breast Tissue Expander* (not breast implants):	☐ No ☐ Yes
Neurostimulator	☐ No ☐ Yes	Cardiac Pacemaker/Defibrillator*/Artificial Valve:	☐ No ☐ Yes
Previous Metallic Orbital Foreign Body?	☐ No ☐ Yes	Implants* What:	☐ No ☐ Yes
Removed?	☐ No ☐ Yes	Patient Claustrophobic	☐ No ☐ Yes
Implanted Infusion Pump	☐ No ☐ Yes	* Prescribe Sedation	
Shrapnel and/or Bullet Where:	☐ No ☐ Yes	Patient is over 60	☐ No ☐ Yes
Metal Worker	☐ No ☐ Yes	Diabetes or Hypertension	☐ No ☐ Yes
Cerebral Aneurysm Coil or Clip:	☐ No ☐ Yes	Severe renal disease	☐ No ☐ Yes
Middle Ear Prosthesis*:	☐ No ☐ Yes	PICC Line/IV Problems	☐ No ☐ Yes

Clinical Information

Exam Requested*:

Reason for Exam/Relevant Clinical History:

Suspected Clinical Diagnosis? (if applicable): _____

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

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

Radiologist Protocol Notes ☐ day ☐ evening ☐ P1 ☐ P2 ☐ P3 ☐ P4 ☐ P5 Initials _____

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PATIENT LABEL

MEDICAL IMAGING PRIORITIZATION AND COMMUNICATION

Place flashcard label here

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: _____