



Royal Victoria Regional Health Centre

Appointment

Date: _____

Time: _____

Scanner: 1.5T 3T

Request for MRI Consultation

Department of Diagnostic Imaging
Royal Victoria Regional Health Centre
Tel. (705) 739.5610
Fax. (705) 739.5649

INPATIENT *must be faxed to: (705) 792-3339 OUTPATIENT

Name: _____ Gender: M F

Address: _____

City: _____ Postal Code: _____

Health Card #: _____

Date of Birth (DD/MM/YYYY): _____

Home #: _____ Cell #: _____

E-mail: _____

Please allow 2 weeks to receive notification of appointment

Area to be examined (be specific): _____

Diagnostic Question/Clinical History: _____

Are you requesting a timed follow-up procedure (e.g., 6 month follow-up)? If yes, date requested (DD/MM/YYYY): _____

Medical History Assessment for out-patient:

Dialysis YES NO

Medical History Assessment for in-patient:

Dialysis YES NO

Serum Creatinine: _____ Date DD/MM/YY: _____

Referring Physician (please print): _____

Address: _____

Tel #: _____ Fax #: _____

Physician Signature: _____

Patient Weight: _____ Patient Height: _____

Ambulation:

Walk Wheelchair Stretcher MEDICAL LIFT

Please list previous pertinent imaging (MANDATORY)

External reports MUST be provided.

Table with 3 columns: What, Where, and rows for MRI, CT, Xray/Mammo, Ultrasound, Other.

If the following information changes between now and the appointment notify the MRI Department.

Inaccurate information can result in appointment cancellation the day of exam.

Table with 5 columns: Indicate if the patient has the following, Yes, No, Question, Yes, No. Contains 18 screening questions.

List all previous surgeries and implants.

No previous surgery

For any implant, provide surgery date/hospital so we may confirm MRI compatibility. Provide OR record to expedite booking.

Verification of screening will be done at appointment

Patient/SDM Signature: _____ Technologist Signature: _____ Date: _____

For Radiologist Use ONLY:

P1 P2 P3 P4 T _____

Protocol

Cancer Stage/Diagnosis Breast Cancer Screen Other

For Booking Use Only:

20 30 45 60 75
GAD 1.5T
BUSCOPAN 3T
WEEKEND GA
WEEKDAY
BOOKING TIME

