

JDMI MRI REQUEST FORM REFERENCE SHEET

Please use this reference sheet as a guide to complete MRI request forms. For easy reference, this guideline has been documented according to sections on the requisition.

Section I: Patient Information

All patient demographic information must be completed

Patient Information		MRI REQUEST	
1	Medical Record No.:	Health Card No.:	Version Code:
	Name: _____	DOB: ____ / ____ / ____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
	<small>First Name Last Name</small>	<small>day month year</small>	
	Address: _____	City: _____	Prov.: _____
	Postal Code: _____		
	Home Tel.: _____	Cell: _____	Business Tel.: _____
2	Mobility Status:	Additional Info.:	
	<input type="checkbox"/> Walking <input type="checkbox"/> Wheelchair <input type="checkbox"/> Stretcher <input type="checkbox"/> Ambulance		
3	Billing Information:	Claim Number/Insurance No.:	
	<input type="checkbox"/> OHIP <input type="checkbox"/> WSIB <input type="checkbox"/> Non Resident/Other	<small>(include attachments if necessary)</small>	

1. Enter the patient's medical record number applicable to the hospital that you are sending the request (if available).
2. Mobility status provides information regarding additional assistance the patient may require; i.e. Hoyer lift and/or patient coming from special institutions such rehab, nursing homes, etc.
3. Billing information indicates the form of payment. If none of the options apply, please comment and attach further documentation.

Section II: Screening Questions

Patients must complete the following section or Referring MDs to complete with patient input.

4	5	6
<p>To be completed by Patient</p> <p>FOR PATIENT SAFETY THESE QUESTIONS</p> <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you had a previous MRI?</p> <p><input type="checkbox"/> <input type="checkbox"/> Has metal ever gone into your eye?</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you have any kidney disease?</p> <p><input type="checkbox"/> <input type="checkbox"/> Are you on dialysis?</p> <p><input type="checkbox"/> <input type="checkbox"/> Could you be pregnant?</p> <p>Date of last Menstrual Period: _____</p> <p>What is your current Weight: _____ <small>(maximum allowable weight 550lbs./250kg, but dependent on girth)</small></p> <p>What is your current Height: _____</p> <p>Patient's Signature: X _____</p>	<p>BE ANSWERED:</p> <p>Do you have any of the following? <small>(check all that apply)</small></p> <p><input type="checkbox"/> Aneurysm Clips</p> <p><input type="checkbox"/> Artificial Cardiac Valve</p> <p><input type="checkbox"/> Cardiac Pacemaker</p> <p><input type="checkbox"/> Cochlear Implants</p> <p><input type="checkbox"/> Coils/Stents</p> <p><input type="checkbox"/> Neurostimulator</p> <p><input type="checkbox"/> Retained Pacing Wires</p> <p><input type="checkbox"/> Shrapnel / Bullets</p> <p>Other Implanted Devices: _____ <small>(add additional pages if necessary)</small></p>	<p>Have you ever had surgery on your <small>(check all that apply)</small></p> <p><input type="checkbox"/> Abdomen/ Pelvis</p> <p><input type="checkbox"/> Arms/ Legs</p> <p><input type="checkbox"/> Chest</p> <p><input type="checkbox"/> Head</p> <p><input type="checkbox"/> Neck</p> <p><input type="checkbox"/> Spine</p> <p>Name all Surgeries: _____</p> <p>Approximate year of surgeries <small>(add additional pages if necessary):</small> _____</p>

4. Yes or No section

- a. Patients who have had an incident of metal in their eyes will require an orbital x-ray prior to the MRI exam. If the patient has had previous orbital x-rays at other hospitals and no further incidents with metal, please submit the previous report and do not re-order x-ray orbital exams.
- b. If your patient has kidney disease, kidney function problems or is on dialysis extra precautions must be taken prior to the MRI exam. MRI contrast agents can cause a rare disorder called Nephrogenic Systemic Fibrosis (NSF) in patients with severe renal impairment for example, those with an eGFR below 30 mL/min. Based on the exam selected for the patient, we may require serum creatinine/eGFR within 3 months of the MRI appointment to determine if the contrast is safe for the patient.

- c. We wish to avoid performing any medical imaging including MRI procedures on pregnant women as a general precaution. To date, there has been no proven study that the use of clinical MRI imaging during pregnancy has produced harmful effects. For those situations where the MRI is strongly indicated, further discussion between referring MDs and Radiologists must occur to determine the risks versus benefits of the exam.
- d. Coordinating the date of a patient's breast MRI exam with their menstrual cycle is a **must** as the breast appearance varies depending on the day of the cycle and can alter the diagnosis. Breast MRI should be performed between days 7-13 of the menstrual cycle.
- e. There are weight and girth restrictions for MRI scanners; this information is used to book your patient appropriately. Patients above certain weight and girth may not be able to have an MRI depending on scanner and procedure type.

5. Implant section

Some implant devices may compromise patient safety in the scanner. Pulling and heating of various implants in the magnet may cause internal harm or death. Accordingly, we request all surgical and procedural information and reports you have about implants, so we can optimize patient safety. We recognize that you may not have the information, however providing as many records you may have or sources for these records will expedite scheduling. This refers to surgeries or procedures completed in a patient's lifetime. Older implants may be more dangerous than newer versions.

Implants that are often incompatible with MRI scanners include pacemakers, neurostimulators, aneurysms clips, and cochlear implants. For other MRI implants, a regular scanner (1.5 Tesla) may be indicated versus a high field scanner (3 Tesla).

6. Listing Surgeries

Previous surgeries help us identify potentially unknown implants in your patient.

Section III: Referring Physician Information

7	Referring Physician Information	8	Exam Information
	Physician's Name: _____ Address: _____ Postal Code: _____ Phone: _____ Fax: _____		Area to be Scanned (<i>be specific</i>): _____ Clinical Information /Working Diagnosis: _____ _____
9	Completed Tests and Associated Results		
	<input type="checkbox"/> MSH <input type="checkbox"/> PMH <input type="checkbox"/> TGH <input type="checkbox"/> TWH <input type="checkbox"/> WCH <input type="checkbox"/> Outside Hospital/Clinic (<i>if from outside hospital, attach outside report</i>)		
	Tests: _____		
	Does the patient require an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what language? _____		
10	Physician's Signature: X _____		

- 7. The radiologist report will be sent to the referring physician office indicated.
- 8. Provide all information necessary for accurate diagnostic purposes, and as much detail as possible regarding clinical information to ensure an appropriate MRI procedure is selected. There are various ways to image each body part and providing an accurate, detailed, clinical history will help us optimize the images obtained.
- 9. All previous related reports are necessary for comparison purposes.
- 10. The MRI exam will be scheduled upon receipt of a complete MRI request form. The MRI **will not be booked** without the signature of the referring physician.