BLUEWATER HEALTH

Bluewater Health

Department of Diagnostic Imaging

89 Norman Street
Sarnia, Ontario N7T 6S3
Ph: 519 464-4491 Fax: 519 383-8536

Request for Magnetic Resonance Imaging

☐ ED ☐ Out Pt ☐ In Pt

Patient Name _____

Address _____

_____ Postal Code _____

Phone: Home _____ Alternate _____

D.O.B. _____ (DD/MM/YYYY) Sex ☐M ☐F

Health Card Number _____ VC _____

Allergies: _____

To MRI Suite Via
☐ Walking ☐ Ambulance ☐ Chair ☐ Stretcher

Incomplete Requests Will Be Returned resulting in a delay of this procedure.

Area to be Examined (Please be specific)

Pertinent History, Clinical and Imaging Findings: If Imaging not performed at Bluewater Health, send copies of reports.

☐ F/U ED ☐ F/U Other

Does the Patient Have Any of the Following Contra-indications

☐ Yes ☐No Cardiac Pacemaker
☐ Yes ☐No Cochlear Implant
☐ Yes ☐No Orthopedic Plate/Pin/Screw
☐ Yes ☐No Prosthesis
☐ Yes ☐No Tattoos/Tattooed Eye Liner
☐ Yes ☐No Cerebral Aneurysm Clip
Make/Model: _____
☐ Yes ☐No Other Implants/metal
Specify: _____

☐ Yes ☐No Hearing Aid
☐ Yes ☐No IUD
☐ Yes ☐No Pregnancy/Breast Feeding
☐ Yes ☐No Dentures/Braces
☐ Yes ☐No Is the patient claustrophobic?
☐ Yes ☐No Artificial Heart Valve
Make/Model: _____
☐ Yes ☐No Does the patient require an oral sedative prescribed by the referring Physician?
☐ Yes ☐No Can the patient lie motionless on their back for 1 hour?

☐ Yes ☐No Penile Implant
☐ Yes ☐No Neurostimulator
☐ Yes ☐No Infusion Pump
☐ Yes ☐No Medication Patches
☐ Yes ☐No Shrapnel/Bullets/Pellets
Where? _____
☐ Yes ☐No Coil / Filter / Stent
Make/Model: _____

☐ Yes ☐No Has the patient ever been a grinder / metal worker / welder and had an eye injury / metal in / around eye?
☐ Yes ☐No Does the patient need assistance with mobility?

If yes, what is required? _____

Previous surgeries (including back) _____

Date of Lab Work (DD/MM/YYYY) _____

Creatinine Level _____ umol/L (required for vascular studies) (Adult M 57-113 F 39-88)

estimated GFR uml/min/1.73m (>90) _____

Weight _____ Kg

Ordering Physician Signature _____ (please also print name)

Date _____ (DD/MM/YYYY)

Family Physician _____ (please print name)

Copy to Physician _____ (please print name)

For Imaging Department use only

G # _____

Appointment Date _____ (DD/MM/YYYY) **at** _____ **hrs.**