Patient Screening to be completed by the Ordering Physician.
Incomplete information will result in the requisition being returned without a booking.

CAMBRIDGE MEMORIAL HOSPITAL
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Cambridge, ON N1R 3G2
Telephone: 519-740-4968
Fax: 519-740-4969

MRI - REQUEST FOR CONSULTATION

1

APPT. DATE: _____ TIME: _____ AM PM

HEALTH CARD # _____

2 PLEASE PRINT

SURNAME FIRST NAME

ADDRESS

CITY POSTAL CODE

TELEPHONE DAY MONTH YEAR (BIRTHDATE)

3 WORKER'S COMPENSATION

CLAIM NO. (If any)

DATE OF ACCIDENT

PLACE OF EMPLOYMENT

D.I. OFFICE USE ONLY!

Received Date: _____

❑ **Contrast**

❑ **Non-Contrast**

PRIORITY:

1. Immediate
2. Inpt/Urgent
3. Cancer staging
4. Non-urgent

TIMED: _____

Medical Reason:

❑ BC Breast Cancer Screening

❑ OT Other

❑ SD Cancer Staging and/or Diagnosis

4 HISTORY, CLINICAL INFORMATION & PRIMARY CONCERN

5 MRI EXAM REQUIRED

6

HEIGHT_____WEIGHT_____

ALLERGIES _____

DIABETES ? ❑ YES ❑ NO

RENAL PATHOLOGY ❑ YES ❑ NO

7 MRI LEVEL OF PRIORITY

URGENT ❑ WHY? _____

SEMI-URGENT ❑ WHY? _____

ROUTINE ❑

8 Does the patient have any of the following?

❑ YES ❑ NO Aneurysm Clip
❑ YES ❑ NO Cardiac Pacemaker
❑ YES ❑ NO Neurostimulator
❑ YES ❑ NO Tattoos and/or body piercings
❑ YES ❑ NO Hearing Aid or cochlear implant
❑ YES ❑ NO Insulin or other infusion pump
❑ YES ❑ NO Is the patient pregnant?
❑ YES ❑ NO Is the patient claustrophobic?
❑ YES ❑ NO Can the patient weight bear?

Has the patient ever had a metallic foreign body in their eye? ❑ YES ❑ NO

If Yes, please have orbital x-ray done and submit report with this requisition

❑ YES ❑ NO Stent, filter or coil
❑ YES ❑ NO Surgical Staples, clips or metallic sutures
❑ YES ❑ NO Bone/Joint (plate, screw, nail, pin, etc.)
❑ YES ❑ NO Prosthesis (eye, penile, limb, etc.)
❑ YES ❑ NO Joint replacement
❑ YES ❑ NO Medication patch

Other Implants: _____

Other Devices: _____

Previous Surgeries: _____

9 ORDERING PHYSICIAN

OC MRP

_____
SIGNATURE

_____
PLEASE PRINT

OTHERS