

REQUEST FOR MR CONSULTATION

Date Received _____ Date Booked _____
(YYYY/MM/DD) (YYYY/MM/DD)

Kingston General Hospital
Imaging Services Department
76 Stuart Street
Kingston, Ontario K7L 2V7
(613) 549-6666, ext 2786 or (613) 548-6096
Fax: (613) 548-2413

Referred by: _____
Physician Name: _____
Physician Specialty: _____
Address _____
Postal Code _____
Phone: _____
Referring Hospital: _____
Inpatient Outpatient Clinic
Floor _____ Wheelchair Stretcher
Copy reports to: _____

PATIENT INFORMATION

KGH CR Number _____
Name _____
Surname Middle First
Date of Birth _____
(Year/Month/Day)
Address _____
City _____ Prov _____
Postal Code _____
Phone: Home _____ Business _____
OHIN Number _____
WSIB Number _____
Alternate Insurance Number _____

Area to be examined (be specific): _____ PT Weight _____
Clinical Information: _____

Working Diagnosis: _____
Differential Diagnosis: _____

Reason for scan: Diagnosis Surgical Planning Radiation Planning Follow-Up
Clinical Priority (1 Emergency <-----> Elective 4) 1 2 3 4

1: urgent/emergent within 24⁰ 2: inpatient within 48⁰ 3: within 10 days 4: beyond 10 days

Previous Relevant Imaging (Where? When?) _____
Previous Relevant Surgery (type): _____ When _____

	Yes	No		Yes	No
Claustrophobic	___	___	Anaesthesia Notified	___	___
Require Sedation/Anaesthesia	___	___	Surgical Aneurysm Clip	___	___
Cardiac Pacemaker	___	___	Previous Eye Injury/foreign Body	___	___
Prosthetic heart valve	___	___	Recent Caval Filter/Stent (<6 months)	___	___
Metallic Foreign Body	___	___	Any Implant (List) _____	Make: _____	
Pregnant	___	___	Model: _____	Date of Insertion: _____	Where: _____
Vascular Access Port/Catheter	___	___			
Impaired Renal Function	___	___	If yes, need eGFR _____	with date: _____	
Previous Gadolinium	___	___	Previous Gadolinium Adverse Reaction _____		

Incomplete or Illegible Requests Will Be Returned Resulting In Delay Or Cancellation of the Study.

Physician Signature: _____ Date: _____
(Year/Month/Day)

Radiologists Protocol: 1: urgent/emergent within 24⁰ 2: inpatient within 48⁰ 3: within 10 days 4: beyond 10 days

Priority: (1 Emergency <-----> Elective 4) 1 2 3 4
Gadolinium: Yes No Dose _____

Approval: Signature _____ Date: _____
(Year/Month/Day)

KINGSTON GENERAL HOSPITAL – MAGNETIC RESONANCE IMAGING

Patient Weight _____
Patient Height _____
Allergies _____

MRI SCREENING FORM

To ensure patient safety, this form **MUST BE COMPLETED**.

I have been informed how the MR examination is performed and that an injection of Gadolinium may be used to enhance the study. I have answered the following questions and agree to the procedure as described.

✓ YES	✓ NO	
		Have you had a previous MRI?
		Have you ever been a metal worker, grinder or welder?
		Have you ever had a metal foreign body in or around the eyes or been exposed to metal dust or slivers?
		Are you pregnant or breast-feeding?
		Are you claustrophobic?
		Are you connected to any supportive medical device?
		Do you have any of the following in place:
		Cardiac Pacemaker, ICD, or Leads
		Heart Valve Prosthesis
		Aneurysm Clip(s)
		Intraventricular Shunt
		Orbital Implants
		Neurostimulator, Bone Growth Stimulator, Biostimulator
		Implanted Drug Infusion Device/Insulin Pump
		Inner Ear Implants – Cochlear, Stapes, Aids
		Joint Replacements/Prosthesis
		Coil, filter or Stent (intravascular)
		Genital Prosthesis/Devices (Penile, diaphragm, IUD)
		Surgical Rods/Wires/Plates
		Vascular access port (PICC line, Swan Ganz, Port-a-cath)
		Dentures, Braces
		Tattoos, Permanent Cosmetics
		Body Piercing, Body Jewellery
		Medication Patches
		Shrapnel/Bullets
		Other Surgeries

Impaired Renal Function _____ eGFR _____ Date _____
 Verbal Consent for IV Gadolinium _____

I have answered these questions to the best of my knowledge.

 Patient/Guardian Signature _____ Date _____

 Tech/Witness Signature _____ Date _____

Clinical History: _____

