The Ottawa Hospital | L'Hôpital d'Ottawa

# MEDICAL IMAGING (MI) REQUISITION
## FAXED REQUISITIONS PREFERRED
**CENTRAL BOOKING OFFICE TELEPHONE - 613-761-4831**

**MI Fax Numbers**

| | | | | | |
|---|---|---|---|---|---|
| CT | 613-761-4529 | Ultrasound | 613-761-4814 | | |
| MRI | 613-737-8611 | Breast Imaging | 613-761-4405 | | |
| X-ray | 613-737-8647 | Angio General | 613-737-8855 | Civic | 613-761-4128 |

Surname | First name | Mother's maiden name

Father's first name:

Street address | Apartment no.

City | Province | Postal Code

Telephone # | Cell:

Home: | Work:

Date of birth /YY /MM /DD | Sex ☐ Male ☐ Female

Provincial insurance | Version | Expiry date

Other insurance

WSIB number | Employer

Medical Record number (MRN) | Registration number

**PRIORITY**
If required as High Priority, please provide appropriate history.
☐ Routine ☐ High Priority ☐ 2-3 days post discharge
☐ Specific date: _____ If specific date, please justify clinical necessity.

**Examination(s) requested:**

CT Head

**Patient history and pertinent lab results:**

Memory problems

**For In-patients** (mode of transportation)
☐ Wheelchair ☐ Stretcher ☐ Bed
☐ Ambulatory ☐ Portable

| | Yes | No |
|---|---|---|
| Oxygen required | ☐ | ☐ |

| Patient weight (kg) | Patient height (cm) | Allergies |
|---|---|---|
| | | |

| Y | N | Please check the following if applicable |
|---|---|---|
| ☐ | ☐ | Patient has renal impairment |
| ☐ | ☐ | Family history of End Stage Renal Disease |
| ☐ | ☐ | Patient is on dialysis |
| ☐ | ☐ | Patient pregnant |
| ☐ | ☐ | Patient on Metformin |
| ☐ | ☐ | None |

**Creatinine Clearance or eGFR and date of test result for patients with equal to 1 or more contrast nephropathy risk factors).**

| Y | N | Contrast Nephropathy Risk Factors |
|---|---|---|
| ☐ | ☐ | Diabetes Mellitus |
| ☐ | ☐ | Cardiac disease |
| ☐ | ☐ | Hypertension |
| ☐ | ☐ | Nephrotoxic drugs: |
| ☐ | ☐ | Immunosuppression: |
| ☐ | ☐ | Collagen vascular disease |
| ☐ | ☐ | Dehydration, sepsis, shock |
| ☐ | ☐ | None |

Please provide the value, date and location of the most recent creatinine or eGFR result within 6 months and provide a report if not performed at TOH.
Location:

| Cr level | eGFR level | Date of test |
|---|---|---|
| | | |

| Y | N | Possible MRI Contraindications |
|---|---|---|
| ☐ | ☐ | Aneurysm surgery |
| ☐ | ☐ | Intraocular lens implant/Prior metal fragment |
| ☐ | ☐ | Eye surgery (excl. lens implants, cataract or laser surgery)* |
| ☐ | ☐ | Ear surgery (excl. ear tubes)* |
| ☐ | ☐ | Cardiac pacemaker * |
| ☐ | ☐ | Implanted stimulators, electrodes, electronic devices * |
| ☐ | ☐ | Any filters, stents, coils, grafts or shunts* |

* Please forward operative report and specify the

| device | date | institution of the surgery/treatment. |
|---|---|---|
| | | |

**MRI is contraindicated for all patients with pacemakers or defibrillators.**

**Breast implants:** ☐ Yes ☐ No
If breast imaging request - Last mammogram: When? Where?
**Research study:** ☐ Yes ☐ No Please specify study name

Ordering Practitioner (Print) | Signature | Billing #

Office Telephone # | Fax# | Pager #

Copy of report to Bruyère Memory Program 75 Bruyère St fax 613-562-6013 | Fax #

**Protocol:**

| Priority Code | Protocoled by | eGFR required? ☐ Yes ☐ No ☐ 1m ☐ 3m | APPOINTMENT DATE | TIME |
|---|---|---|---|---|
| | | | | |

Radiologist/ Technologist Printed name: | Signature:

**Comments:**

Radiologist involved | Exam time

Images sent to | Technologist's signature