	Annaintment							
D(•/L	Appointment			l T ∗ <u>must</u> be faxed	to: (705) 792-3339	DUTPAT	IENT	
KVI	Date:		Nama		C	andor: - N	ı	
Royal Victoria	Time:				Ge	ander: □ ivi	ı or	
Regional Health Centre	Tillie		Address:		Postal Code:			
	Scanner: 1.5	T 3T	Health Card #:		1 00101 0000			
Request for MRI Cor	ısultation		_):			
Department of Diagnostic Imaging			Home #: Cell #:					
Royal Victoria Regional Health Centre			E-mail: *Please allow 2 weeks to receive notification of appointment*					
Tel. (705) 739.5610 Fax. (705) 739.5649			*Please allow 2	2 weeks to re	eceive notification of	f appointm	ient*	
Area to be examined (be sp	pecific):							
Diagnostic Question/Clinica								
						 		
				· · · · · · · · · · · · · · · · · · ·		 		
Are you requesting a time of	felless up procedur	o /o a C month fo	allow up 2 If you do		(DD//////////	····		
Are you requesting a timed								
Medical History Assessr Dialysis YES	Referring Physician (please print):Address:							
Didiyolo = 120	Tel #: Fax #:							
Medical History Assessr	Physician Signature:							
Dialysis Creatining:	Physician Signa	ture:						
Serum Creatinine: Date DD/MM/YY: Please list previous pertinent Imaging (MANDATORY)								
Patient Weight: Patient Height:			External reports N					
				What	Where			
Ambulation:			MRI					
☐ Walk ☐ Wheelchair	☐ Stretcher ☐	MEDICAL LIFT	СТ					
			Xray/Mammo Ultrasound					
			Other					
If the following information of	changes between no	w and the appoint	.1	RI Department		·····	l	
Inaccurate information ca	n result in appointr	ment cancellation						
Indicate if the patient has the following: Yes No 1. Previous reaction to contrast used for MRI?			Yes No 10. Coils, Filters, or Stents? If yes, provide the location					
If yes, state the reaction typ		_	in the body:					
2. Claustrophobia?	. Claustrophobia?			11. Neurostimulation System/Other Stimulation				
If yes, physician to prescribe sedation 3. Have you ever had metal go into your eye that			Device? Type: 12. Programmable shunt?					
was not removed by a doctor?			(spinal or intraventricular)					
If yes, attach orbit x-ray report			13. IUD Type:					
4. Any metallic fragment or	foreign body?		14. Spinal surgery	y?	D-4			
(shrapnel, bullets) 5. Currently pregnant?			Level of sx: Date: 15. Breast Tissue expander? Type:					
6. Pacemaker/Defibrillator/ICD?			16. Drug infusion pump or glucose monitor?					
7. Prosthetic Heart Valve, Cardiac Closure or Occluder Device? Type:			17. Any type of prosthesis? (eye, penile, etc.) If yes, explain:					
8. Cerebral Aneurysm Clips?			18. Any other metallic, magnetic or electronic implant?					
9. Cochlear (ear) implant?			If yes, explain:		·			
List <u>all</u> previous surgeries a	nd implants.							
\square No previous surgery								
			5 145					
			onfirm MRI compatib	ollity. Provide (OR record to expedite	booking.		
Verification of screening will be done at appointment Patient/SDM Signature:					Date:			
For Radiologist Use ONLY:					For Booking Use O	nlv:		
•					_	-	_	
□ P1 □ P2 □ P3 □ P4 □ T					□ 20 □ 30 □ 4 □ GAD	.5 □ 60 □ 1.5T	□ 75	
Protocol					☐ BUSCOPAN	□ 1.51		
					☐ WEEKEND	□ GA		
					☐ WEEKDAY			
					☐ BOOKING TIME			
□ Cancer Stage/Diagnos	sis							