Shared health Soins communs Manitoba

Fax non-emergent MRI requests to 204-926-3650 (in Winnipeg) / 1-866-210-6119 (outside of Winnipeg)

MRI Request Form

Incomplete / illegible forms will be returned.

Outpatient: ◯ 1st appt. available (Winnipeg Only)

◯ Will travel within Manitoba for 1st available appt.

◯ Preferred Site- Specify:

ED Outpatient ☐ Time order placed: _____

Follow up with: ☐ ED Physician

☐ Primary Care Provider

Patient Contact #:

Patient Name:

Inpatient/ED ☐ Site _____

Ward / Room # ☐ EMS Transport

PATIENT INFORMATION

***Last Name/ First Name:**

***DOB:** yyyy/mmm/dd Age:

***Sex** ◯ Male ◯ Female

MHSC:

***PHIN:**

Other Insurance? ◯ Yes ◯ No WCB #

Full Address:

Email Address:

***Phone: Daytime** _____ **Mobile:** _____

Emergency Contact/ Next of Kin: _____

Translator ☐ Language Required:

Research Study? Use Research Requisition Form

SCHEDULING (Note: Radiologist will use expert and evidence-based criteria to prioritize request)

URGENCY: ◯ Emergent (contact radiologist directly) ◯ Urgent ◯ Elective Requested Date: _____

TRANSPORT: ☐ Ambulatory ☐ Wheelchair ☐ Bed/Stretcher ☐ Lift Required

Pregnant? ◯ Y ◯ N LMP: yyyy/mmm/dd

Claustrophobia ◯ Y ◯ N Requires Sedation? ◯ Y ◯ N

Infection control precautions? ◯ Y ◯ N Specify:

Pre-Sedation form required for pediatric patients under 10 years

EXAM INFORMATION

***Weight (kg):** _____

***Height (cm):** _____

***Allergies related to imaging?** (contrast, latex, sedative medication): _____

Pediatric Patients (≤ 2 years old): provide head circumference percentile:

***Anatomical location / examination requested:**	**Previous Relevant Exams**	**Location**	**Date**

***RELEVANT CLINICAL/ SURGICAL HISTORY:**

Cancer Care Pathway ☐ Y **Previous Back Surgery?** ☐ Y

FOR IV CONTRAST EXAMS

◯ Y ◯ N Renal disease (**Any of:** Dialysis, Renal transplant, Single kidney, kidney surgery, cancer involving kidney(s))

If Y, then please provide most recent SCr: eGFR: Date: PICC/ CVC/ Port? ◯ Y ◯ N

PRE-APPOINTMENT SCREENING (attach implant records to requisition)

	Y	N		Y	N
Pacemaker / defibrillator	◯	◯	Drug infusion pump/ glucose monitoring device	◯	◯
Neuro or spinal cord stimulator	◯	◯	Surgical implants (e.g. aneurysm/ surgical clips, coil, eye / ear implant, electrodes)	◯	◯
Loop recorder	◯	◯	Welder / work with metal / any metal in eyes (if yes, send orbital X-ray report ASAP)	◯	◯
STRATA valve	◯	◯	Bullet / shrapnel or other metal foreign body	◯	◯
Cochlear implant	◯	◯	Other:	◯	◯

ORDERING CLINICIAN

* Clinician Signature *Clinician Name (print first & last) Billing # Fax # 24 hr. Critical Results Contact #

Address Phone # Date Ordered Time Ordered (24 hr.)

Copy to: Clinician Name Location Phone # Fax #

All requests will be distributed to an appropriate location. For Emergent Requests, please call Radiologist directly.

Required Information is marked with an "*" and must be completed or the request will be declined.