PRAIRIE MOUNTAIN HEALTH

Brandon Regional Health Centre
Diagnostic Imaging Services
Downtime
1-855-578-4032
204-578-4032 (Fax) 1-204-578-4986

BRHC Use Only:

HRN: _____

ADM: _____

Appointment Date & Time: _____ yyyy/mmm/dd hh:mm

PHYSICIAN INFORMATION:

Ordering Physician (Please Print):

_____

Physician Phone: _____

Physician Fax: _____

Copy of Report To: _____

Physician Signature:

_____

Physician Billing #: _____

PATIENT INFORMATION:

Last Name: _____ First Name: _____

MHSC _____ DOB _____ yyyy/mmm/dd Age: _____

PHIN _____ Sex ☐ Male ☐ Female

Other Insurance No. _____ WCB ☐ Yes ☐ No

Address

_____

City Province Postal Code

Phone: Home (___)_____ Work (___)_____ Cell (___)_____

MODALITY: ☐ X-Ray ☐ Ultrasound ☐ Echocardiography ☐ CT ☐ Mammography ☐ MRI ☐ Nuclear Medicine

☐ PLEASE CHECK FOR APPROVAL IF RADIOLOGIST RECOMMENDS MODALITY CHANGE

☐ **Emergent** (Must contact Radiologist)

☐ Urgent ☐ Elective

Allergies: _____

Previous Relevant Exams	Date (Y/M/D)	Location
1.		
2.		

EXAMINATION Requested

☐ **Translator Required**

_____ (Language)

Relevant Clinical History/Information (print / Typed)

MUST COMPLETE FOR ALL EXAMS

Patient Weight _____

Patient Height _____

Is Patient Pregnant ☐ Yes ☐ No

Last Menstrual Period _____ yyyy/mmm/dd

BHCG Level + ☐ - ☐

Breastfeeding ☐ Yes ☐ No

REQUIRED FOR CT, MRI, ANGIO, INTERVENTIONAL EXAMS

Allergy to X-Ray dye ☐ Yes ☐ No

Contrast media can reduce renal function in patients with the following risk factors (check all that apply):

☐ Renal Disease ☐ Receiving Metformin ☐ Interleukin, NSAIDs

☐ Solitary Kidney ☐ Organ Transplant ☐ Previous Chemo

☐ Diabetes ☐ Myeloma ☐ Age greater than 70 years ☐ Vascular Disease

☐ Human Immunodeficiency Syndrome ☐ No Risk Factors

Patient on hemodialysis ☐ Yes ☐ No Patient on peritoneal dialysis ☐ Yes ☐ No

If any above checked (required to be submitted with request form)**:**

☐ Serum Creatinine ☐ EGFR

Level _____ Date Drawn _____ yyyy/mmm/dd Level _____ Date Drawn _____ yyyy/mmm/dd

Must complete for ALL MRI Exams for PATIENT SAFETY.
MRI EXAMINATION WILL NOT BE BOOKED UNLESS BELOW SECTION HAS BEEN COMPLETED IN FULL.

Check conditions that apply:

☐ Heart Valve ☐ Previous eye surgery

☐ Aneurysm surgery or clips. If YES forward surgical report to MRI

☐ Implanted devices; i.e. stimulators, shunts, electrodes, inner ear implants

☐ Has patient ever operated welding equipment or metal machining

☐ Metal in eyes. If YES forward orbit x-ray report to MRI

If **YES**, patient cannot be scanned (at this facility)

Cardiac Pacemaker/Defibrillator ☐ Yes ☐ No

Strata Valve ☐ Yes ☐ No

☐ Claustrophobic, and/or medical condition that requires sedation

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G634