**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

Pre-Sedation form required for pediatric patients under 10 years

Infection control precautions? ☐ Y ☐ N Specify:

**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.**