MRI Consultation/Demande de consultation IRM

Timmins and District Hospital / Hôpital de Timmins et du district
John P. Larche Medical Imaging & Cardiopulmonary Department
Service d'imagerie médicale et de soins cardio-pulmonaires John P. Larche

Phone: 705-360-6677 | **Fax:** 705-267-6346 | **E-mail:** imaging@tadh.com

HOSPITAL USE ONLY

Allergies:

PRECAUTIONS

DROPLET ☐

AIRBORNE ☐

CONTACT ☐

Patient Name: ______

Date of Birth: ______ (dd / mm / yyyy) Weight (lbs/kg): ______ (for medication on some procedures)

Address: ______ Apt. #: ______

City: ______ Postal Code: ______

Phone (Home): ______ Work: ______

Health Card #: ______

SIN #: (for WCB Claims) Claim #:

Area to be scanned/Zone à examiner ______

Clinical Indication/Question diagnostique ______

Previous Surgery/Chirurgie antérieure ______ When/Quand ______

Ordering Physician/Médecin traitant ______

X ______ ______
Signature of Referring M.D. / Signature du Médecin traitant: Date

Address/Addresse: ______

Tel: ______ Fax: ______

Copy to Family Physician: Dr ______ Tel. # ______

Copy to Other Physician: Dr ______ Tel. # ______

FOR RADIOLOGIST USE ONLY/RESERVÉ AU RADIOLOGUE

		CLINICAL INDICATION FOR SCAN	
	BC ☐	**MRI Breast Screening**	
	OT ☐	**Other**	
	SD ☐	**Cancer Staging/Diagnosis**	

DIAGNOSTIC IMAGING - MRI and CT Priority Assessment Tool

Priority Level	Descriptions	Access Target
1 ☐	Emergent	Immediate
2 ☐	Inpatient Urgent	Within 48 hours
3 ☐	Semi-Urgent	Within 10 days
4 ☐	Non-Urgent	Within 4 weeks

Contrast Yes/Oui ☐ No/Non ☐

Has the patient ever had/Le patient a déja eu:	**Yes/Oui**	**No/Non**
Pacemaker/stimulateur cardiaque	____	____
Aneurysm clips/clips pour anévrisme	____	____
Cochlear (middle ear) implant/implant cochléaire	____	____
Prosthetic heart valve/valvule prothétique	____	____
Neurostimulator device/neuroprothèse	____	____
Other implants/autre implants	____	____
If yes/Si oui		
Company/Companie: ______	____	____
Model No./No. de modèle ______	____	____
Metal fragments in eyes or other Métal dans les yeux ou autres	____	____
Implanted insulin, continuous glucose monitor/sensor, chemotherapy pump Pomp implanté (insuline/chimiothérapie)	____	____
Claustrophobia/claustrophobie	____	____
Chance of pregnancy/chance de grossesse	____	____

For TDH Schedulers Only
Réservé aux commis aux rendez-vous de HTD

Date Requisition Received/ ______
Date de réception de la l'examen

Scheduled Exam Date/ ______
Date de l'examen

Exam Time ______
Heure de l'examen

Creatinine/eGFR: **Order if patient has one or more risks**

☐ Greater than 60 years of age	☐ Renal Surgery
☐ Dialysis	☐ Diabetes Mellitus
☐ Renal Transplant	☐ High blood pressure requiring medical therapy
☐ Single Kidney	**** Do not discontinue Metformin**
☐ Renal Cancer	