DIAGNOSTIC SERVICES MANITOBA | SERVICES DIAGNOSTIC MANITOBA

Selkirk Regional Health Centre
Fax to 204-785-7427

MRI Request for Consultation

Date: **HRN:**
Patient:
DOB:
Prov HC #:
Doctor:
Clinic/Unit: **Loc'n**

Date exam needed:
_____
O ER
O Outpatient
O Inpatient: _____(site/unit)

Method of Transport:
o wheelchair
o stretcher
o ambulatory
o bed
o will require lift

Sex: O Male O Female
Other Insurance #:_____ WCB #:_____
Patient Address:_____
City:_____ Province:_____
Postal Code:_____

REQUIRED
Patient Height: _____
Patient Weight: _____
Pregnant: o Yes o No

Patient Phone Numbers:
Daytime Phone#:_____ Cell:_____ Home Phone/Other:_____
Emergency Contact/Next of Kin:_____ Maiden Name:_____

Examination Requested:

o Emergent* o Urgent o Elective
(*Must contact Radiologist for emergent requests)

History and Provisional Diagnosis. Patient Infection Control Precautions? Specify

Previous Relevant Exams	Test Type/ Name	Site	Date
1 _____	_____	_____	_____
2 _____	_____	_____	_____
3 _____	_____	_____	_____

MUST COMPLETE FOR ALL EXAMS

Cardiac pacemaker?
o Yes o No
(If yes, patient cannot be scanned)

Is patient ≤ 12 years old?
o Yes o No
(If yes, send request to HSC)

CHECK *ALL* CONDITIONS THAT APPLY

o Implanted Devices? (Defibrillators, stimulators, shunts, electrodes, pumps, strata or heart valve, inner ear implants, etc.)
Specify: _____
o Brain surgery/aneurysm surgery/aneurysm clips? (If yes, forward OR report)
o Metal in eyes from welding/grinding/sheet metal worker? (If yes, send orbit x-ray report)
o Previous eye or ear surgery? (Please specify:_____)
o Claustrophobia or other medical condition requiring sedation? (Please refer to RIS patient appointment letter)
o Patient cannot lie supine for 30 minutes

For contrast enhanced exams:
Patient on hemodialysis or peritoneal dialysis? o Yes o No Specify dialysis type:_____
Serum creatinine > 250 umol/L or GFR < 30 mL/ min o Yes o No

FOR CONTRAST ENHANCED EXAMS

If contrast media is required, no solid food for 4 hours prior to study. Normal fluid intake. If the patient is diabetic, please adjust medication accordingly. Contrast media can reduce renal function in patients with the following risk factors: (Check all that apply)

o Kidney disease o Collagen Vascular Disease o Receiving Metformin, Interleukin, NSAIDs o Diabetes
o Myeloma o Age >65 years

For these at risk patients:
- Provide serum creatinine (within 90 days of exam; < 30 days if known renal disease) _____

Physician and Clinic Information **ALL FIELDS REQUIRED**

Print:_____ Sign:_____ MD MHSC Billing #_____
Physician signature or delegate (Print) (Sign)

Clinic Name & Address: _____ Phone # _____ Fax # _____
After Hours Emergency Contact #: _____ Physician Address: _____

***If additional report is required, please complete the following:**

Name of Physician:_____ Clinic Name & Address:_____ Phone #:_____ Fax #:_____

Section to be completed by Radiologist- Office Use only Date exam required: _____

TRIAGE CODE: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ New cancer Dx: within 7 days