The Ottawa Hospital | L'Hôpital d'Ottawa

MEDICAL IMAGING (MI) REQUISITION
FAXED REQUISITIONS PREFERRED

CENTRAL BOOKING OFFICE TELEPHONE - 613-761-4831

MI Fax Numbers

CT	613-761-4529	**Ultrasound**	613-761-4814		
MRI	613-737-8611	**Breast Imaging**	613-761-4405		
X-ray	613-737-8647	**Angio** General	613-737-8855	Civic	613-761-4128

Surname First name Mother's maiden name

Father's first name:

Street address Apartment no.

City Province Postal Code

Telephone # Cell:

Home: Work:

Date of birth /YY /MM /DD

Sex ❑ Male ❑ Female

Provincial insurance Version Expiry date

Other insurance

WSIB number Employer

Medical Record number (MRN) Registration number

PRIORITY
If required as High Priority, please provide appropriate history.
❑ Routine ❑ High Priority ❑ 2-3 days post discharge
❑ Specific date: _____ If specific date, please justify clinical necessity.

Examination(s) requested:

Patient history and pertinent lab results:

For In-patients (mode of transportation)
❑ Wheelchair ❑ Stretcher ❑ Bed
❑ Ambulatory ❑ Portable

Yes No
Oxygen required ❑

Patient weight (kg)	**Patient height (cm)**	**Allergies** ❑

Y	N	**Please check the following if applicable**
❑	❑	Patient has renal impairment
❑	❑	Family history of End Stage Renal Disease
❑	❑	Patient is on dialysis
❑	❑	Patient pregnant ❑
❑		Patient on Metformin ❑
❑		None

Creatinine Clearance or eGFR and date of test result for patients with equal to 1 or more contrast nephropathy risk factors).

Y	N	**Contrast Nephropathy Risk Factors**
❑	❑	Diabetes Mellitus
❑	❑	Cardiac disease
❑	❑	Hypertension
❑	❑	Nephrotoxic drugs:
❑	❑	Immunosuppression:
❑	❑	Collagen vascular disease
❑	❑	Dehydration, sepsis, shock
❑	❑	None

Please provide the value, date and location of the most recent creatinine or eGFR result within 6 months and provide a report if not performed at TOH.
Location:

Cr level	**eGFR level**	**Date of test**

Y	N	**Possible MRI Contraindications**
❑	❑	Aneurysm surgery
❑	❑	Intraocular lens implant/Prior metal fragment
❑	❑	Eye surgery (excl. lens implants, cataract or laser surgery)*
❑	❑	Ear surgery (excl. ear tubes)*
❑	❑	Cardiac pacemaker *
❑	❑	Implanted stimulators, electrodes, electronic devices *❑
❑		Any filters, stents, coils, grafts or shunts*

* Please forward operative report and specify the **device** **date** **institution** of the surgery/treatment.

MRI is contraindicated for all patients with pacemakers or defibrillators.

Breast implants: ❑ Yes ❑ No

If breast imaging request - Last mammogram:
When? Where?

Research study: ❑ Yes ❑ No Please specify study name

Ordering Practitioner (Print) Signature Billing #

Office Telephone # Fax# Pager #

Copy of report to Address Fax #

Protocol:

Priority Code	**Protocoled by**	**eGFR required?** ❑ Yes ❑ No ❑ 1m ❑ 3m	**APPOINTMENT DATE**	**TIME**

Radiologist/ Technologist Printed name: Signature:

Comments:

Radiologist involved	Exam time

Images sent to	Technologist's signature

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