REQUEST FOR DIAGNOSTIC CONSULTATION

Departments of Diagnostic Imaging, PEI

☐ **QEH** Phone: 902-894-2944 ☐ **PCH** Phone: 902-438-4329

☐ **KCMH** Phone: 902-838-0757 ☐ **Souris H** Phone: 902-687-7150

☐ **Western** & **CHO** Toll Free: 1-833-565-1380 or Phone: 902-853-3163

NAME: _____ **CELL PHONE:** _____ (SMS/text? ☐ Yes ☐ No)

MRN: _____ **DOB:** _____ **SECONDARY PHONE:** _____

ADDRESS: _____ **E-MAIL ADDRESS:** _____

☐ **ER/IP (Room/location):** _____ ☐ **LIFT REQUIRED** ☐ **WALK**
☐Dept. of National Defense (DND) ☐ **CHAIR**
☐Veterans' Affairs Canada (VAC) ☐Non-Canadian Resident
☐WCB (Employer _____Case # _____) ☐RCMP

PRIORITY:
☐ Emergency ☐ Urgent
☐ Semi-Urgent ☐ Routine

EXAM REQUESTED (Include specific area of interest):

☐ General Radiography: _____

☐ CT Scan: _____

☐ Nuc Med: _____

☐ BMD: _____

☐ Mammography: _____

☐ Ultrasound: _____

☐ MRI: _____

***** COMPLETE REVERSE SIDE FOR MRI *****

Need an X-ray Appointment?
Book online at QEH or PCH through the Health PEI Diagnostic Imaging website

CT/Angio/MRI Procedures:
CR/GFR: _____
Metformin: ☐ YES ☐ NO

PREGNANT? ☐ YES ☐ NO
(LMP) _____
ALLERGIES: _____

PROVISIONAL DIAGNOSIS:

CLINICAL HISTORY: _____

_____

_____

MALIGNANCY? ☐ YES ☐ NO (Elaborate) _____

Relevant Previous Imaging:
CT: ☐ Yes ☐ No _____
US: ☐ Yes ☐ No _____
MRI: ☐ Yes ☐ No _____
Nuc Med: ☐ Yes ☐ No _____
X-ray: ☐ Yes ☐ No _____
Mammo: ☐ Yes ☐ No _____

Tech: _____
Fluoro time: _____
Images sent to PACS: _____
Exp: _____
Pb used: _____
Tech Notes:

Radiologist: _____
Priority ☐ P1 ☐ P2 ☐ P3
Protocol:

Contrast consent obtained by technologist: ☐ Yes ☐ No _____

Physician/NP Name (print): _____ Signature: _____

Date: _____ Office Phone #: _____ Fax #: _____

Extra Report To: _____ Fax #: _____

COMPLETE IN FULL FOR MRI ACCESS (Requisition **WILL BE RETURNED** if not complete)

Patient's weight: _____ lbs _____kg

Yes No PLEASE ANSWER THE FOLLOWING QUESTIONS:

O O Has the patient **EVER** had a **METAL INJURY TO THE EYES**?
If ***YES***; was it removed? _____

O O Is the patient **CLAUSTROPHOBIC**?

O O Does the patient require sedation? (ex: Ativan)
If *YES*, this **MUST** be prescribed by Referring Physician. MRI does not supply Medication.

O O Is the patient **PREGNANT** or **BREASTFEEDING**? If yes, due date? _____

O O History of kidney disease, kidney failure or dialysis?
If yes, last Creatinine and date performed? _____

Yes No PLEASE INDICATE IF THE PATIENT HAS ANY OF THE FOLLOWING:

O O Cardiac **PACEMAKER** or Pacemaker wires (Epicardial Leads)

O O Intracranial **ANEURYSM CLIPS** or **COILS** (Brain)

O O Eye surgery or **EYE IMPLANTS**
Please provide details _____

O O Ear surgery or **EAR IMPLANTS**
Please provide details _____

O O **PENILE** Implant

O O Breast tissue **EXPANDER** or breast implants

O O Neuro-**STIMULATORS**, bio-stimulators, or bone growth stimulators

O O Automatic **DEFIBRILLATOR** or **VENA CAVA FILTER**

O O Artificial **HEART VALVE**

O O Intracranial **SHUNT** (Brain)

O O Intravascular **COILS**, filters, or catheters (Blood vessel)

O O Medication infusion **PUMP** (Insulin, antibiotics, etc) (MUST be removed prior to scan)

O O Orthopedic devices (Artificial joint, prosthetic limb, screw, nail, plate, wire, etc)

O O Shrapnel, bullets or foreign objects

O O Body piercings (**MUST BE REMOVED BY PATIENT PRIOR TO SCAN**)

I have answered the above questions to the best of my ability. Please consult with the MRI Department if you have any questions regarding the information on this form.

Form Completed by: _____ Date: _____