

KMH CARDIOLOGY CENTRES INC.

BREAST MRI

Markham Fax: (905) 731-6419

Patient Last Name: _____ Patient First Name: _____ DOB: _____
mm/dd/yy
 Patient Address: _____
 Email (optional): _____
 Day Phone #: _____ Home Phone #: _____ Weight: _____
 Third Party Payor: _____ Claim #: _____

1. Please complete form and fax to KMH.
2. See back for completion instructions.
3. This test is not covered by OHIP.

ABSOLUTE CONTRAINDICATIONS FOR BREAST MRI

- Cardiac Pacemakers
 - Internal hearing aids
 - Chest Surgery
- Neurostimulator devices
 - Cochlear implants
 - Embolisation coils
- Any type of electronic, mechanic or magnetic implant
 - Known anaphylactic reaction to latex compounds
 - Aneurysmal clips

CLINICAL INDICATIONS

- Rule out cancer Staging for breast cancer High Risk Screening
- Response to Neoadjuvant Chemotherapy Implant integrity Post OP assessment

PATIENT SCREENING (to be completed by referring physician): These items may interfere with an MRI scan, some may be hazardous. Answer Yes or No to these questions.

Does the patient have any of the following:

	YES	NO		YES	NO
Aneurysm Clips	<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have known kidney disease, solitary kidney or is on dialysis?	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Cardiac Valve	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please attach eGFR/serum creatinine		
Cardiac Pacemaker/Retained Pacing Wires	<input type="checkbox"/>	<input type="checkbox"/>	Is there a possibility of pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
Cochlear Implants	<input type="checkbox"/>	<input type="checkbox"/>	Does the patient need physical aids to walk?	<input type="checkbox"/>	<input type="checkbox"/>
Coils/Filters/Stents	<input type="checkbox"/>	<input type="checkbox"/>	Is the patient claustrophobic? If yes, prescribe sedation	<input type="checkbox"/>	<input type="checkbox"/>
Neurostimulator	<input type="checkbox"/>	<input type="checkbox"/>	Has the patient ever had surgery? If yes, provide details below.	<input type="checkbox"/>	<input type="checkbox"/>
Shrapnel/Bullets	<input type="checkbox"/>	<input type="checkbox"/>	Date of patient's last menstrual period _____		
Tattoos, Tattooed make-up or body piercing	<input type="checkbox"/>	<input type="checkbox"/>	Previous personal history of breast cancer? If yes, when? _____	<input type="checkbox"/>	<input type="checkbox"/>
Other Implanted Devices: _____	<input type="checkbox"/>	<input type="checkbox"/>	First degree relative (parent, sibling or child) with a history of breast cancer?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify type of stent/other devices and fax reports			If yes, what age? _____		
Is the patient breast feeding?	<input type="checkbox"/>	<input type="checkbox"/>	Any spontaneous bloody or clear nipple discharge?	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient had a previous MRI?	<input type="checkbox"/>	<input type="checkbox"/>	Any lump or skin discolouration? If yes, please mark on diagram provided.	<input type="checkbox"/>	<input type="checkbox"/>
If yes, had the patient ever had a problem during an MRI scan or a contrast reaction?	<input type="checkbox"/>	<input type="checkbox"/>	Does that patient have breast implants?	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient ever had metal in the eye?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, Silicone <input type="checkbox"/> Saline <input type="checkbox"/>		
If yes, orbital x-ray results are required (see #6 on back for details)			If yes, additional details: _____		

PREVIOUS TESTS TO DATE (If yes, report copies MANDATORY)

Previous Breast MRI? YES NO When and where: _____

Previous mammograms? YES NO When and where: _____

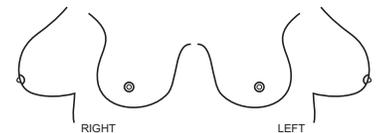
Previous breast ultrasound? YES NO When and where: _____

Previous biopsy or surgery of either breast? YES NO When and where: _____

Right Breast BX location and date: _____

Left Breast BX location and date: _____

Please mark locations of any lumps, biopsy areas, scars, anomalies on the diagram below:



REASON FOR THE TEST

Incomplete requisitions, as well as missing reason for test, clinical information and relevant previous reports will result in delays in scheduling the appointment while we follow-up and request missing information from your office.

KMH USE ONLY Contrast: YES NO

Protocol: _____

REFERRING PHYSICIAN INFORMATION

Surname _____ First Name: _____

Referring Physician's Signature: _____

Billing #: _____

Tel: _____ Fax: _____

Email (optional): _____

CC Physician: _____

Referring Physician's Stamp:

KMH would appreciate your assistance in following the procedures outlined below in order to minimize delays and expedite scheduling of Breast MRI appointments.

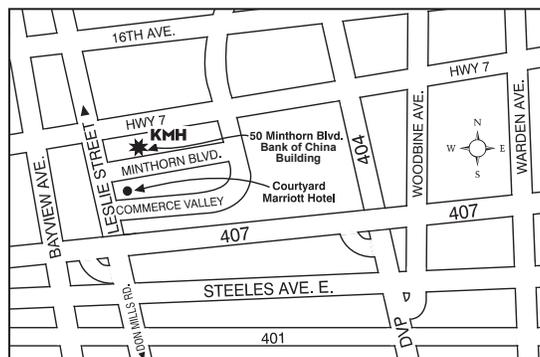
1. At the top of the page clearly indicate:

- a. If **urgent** and reason for urgency.
- b. If **third party** study, payor name and claim number.
- c. Type of **surgery/consultation** which is already booked.
- d. Date of **surgery/consultation**, if already booked.

2. Please provide **accurate and current patient demographic information**, especially day and home telephone numbers so that we can contact the patient and book the appointment.
3. **Reason for performing the test**, relevant clinical information as well as reports from relevant previous diagnostic tests must accompany the requisition to ensure that our radiologist can assign the correct protocol.
4. It is critical for patient safety that the **screening form is fully completed** by the referring physician.
5. For patients who have been injured by metal in the eye, please send patient for orbital x-rays now and fax the results with this requisition.
6. Please ensure that the requisition is signed by the referring physician and has the physician's stamp.
7. Forward the completed **Breast MRI requisition, relevant clinical information and previous reports by fax or mail to the Markham centre.**
8. Incomplete requisitions, as well as missing reason for test, clinical information and relevant previous reports will result in delays in scheduling the appointment while we follow-up and request missing information from your office.
9. Completed requisitions will be assigned a protocol by KMH's radiologist. The patient will be contacted to book the appointment. Once the appointment has been made, KMH will notify your office regarding the time and date.

Please feel free to call us to confirm the status of your request at
1-877-KMH-LABS (564-5227)

**Maps
Not To
Scale**



MARKHAM

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