KMH CARDIOLOGY CENTRES INC.

MRI

Kitchener Fax: (519) 569-7069 • Markham Fax: (905) 731-6419

Patient Last Name: _____ First Name: _____ DOB: _____ (mm/dd/yy)

Address: _____

Email (optional): _____

Day Phone #: _____ Home Phone #: _____ **Weight:** _____

OHIP: _____ Gender: _____

Third Party Payor: _____ Claim #: _____

❑ **URGENT*** *(Check if applicable)*

Reason: _____

1. **Please complete form and fax to KMH**
2. **See back for completion instructions.**

ABSOLUTE CONTRAINDICATIONS FOR MAGNETIC RESONANCE IMAGING (MRI)

- **Any type of electronic, mechanic or magnetic implant**
- **Aneurysmal clips**
- **Cardiac pacemakers**
- **Cochlear implants**
- **Embolisation coils**
- **Internal hearing aids**
- **Neurostimulator devices**

AREA TO BE SCANNED:

_____

CLINICAL INFORMATION/WORKING DIAGNOSIS

_____

_____

_____

_____

KMH USE ONLY Contrast: ❑ YES ❑ NO

Protocol: _____

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
Aneurysm Clips	❑	❑
Artificial Cardiac Valve	❑	❑
Cardiac Pacemaker/Retained Pacing Wires	❑	❑
Cochlear Implants	❑	❑
Coils/Filters/Stents	❑	❑
Neurostimulator	❑	❑
Shrapnel/Bullets	❑	❑
Tattoos, Tattooed make-up or body piercing	❑	❑
Other Implanted Devices: _____	❑	❑
If yes, specify type of stent/other devices and fax reports O		

	YES	NO
Has the patient had a previous MRI?	❑	❑
If yes, had the patient ever had a problem during an MRI scan or a contrast reaction?	❑	❑
Has the patient ever had metal in the eye?	❑	❑
If yes, orbital x-ray results are required (see #6 on back for details) O		
Does the patient have known kidney disease, solitary kidney or is on dialysis?	❑	❑
If yes, please attach eGFR/serum creatinine O		
Is the patient breast feeding?	❑	❑
Is there a possibility of pregnancy?	❑	❑
Does the patient need physical aids to walk?	❑	❑
Is the patient claustrophobic? If yes, prescribe sedation O	❑	❑
Has the patient ever had surgery? If yes, provide details below.	❑	❑

If you have checked YES to any of the questions above, please supply details: _____

_____

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

MRI YES ❑ NO ❑ Nuclear Medicine YES ❑ NO ❑ CT YES ❑ NO ❑ US YES ❑ NO ❑ X-ray YES ❑ NO ❑ Other YES ❑ NO ❑ _____

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.

REFERRING PHYSICIAN INFORMATION

Surname _____ First Name: _____

Referring Physician's Stamp:

Referring Physician's Signature: _____

Billing #: _____

Tel: _____ Fax: _____

Email (optional): _____

CC Physician: _____

KMH would appreciate your assistance in following the procedures outlined below in order to minimize delays and expedite scheduling of 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 . Area of interest must clearly be marked. Please do not identify more than **3 areas of interest.** Our radiologist would be pleased to help you in your selection or we can help to arrange a specialist consult, if necessary.

4. **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.

5. It is critical for patient safety that the **screening form is fully completed** by the referring physician.

6. 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.

7. Please ensure that the requisition is signed by the referring physician and has the physician's stamp.

8. Forward the completed **MRI requisition, relevant clinical information and previous reports by fax or mail to the MRI location of your choice.**

9. 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**.**

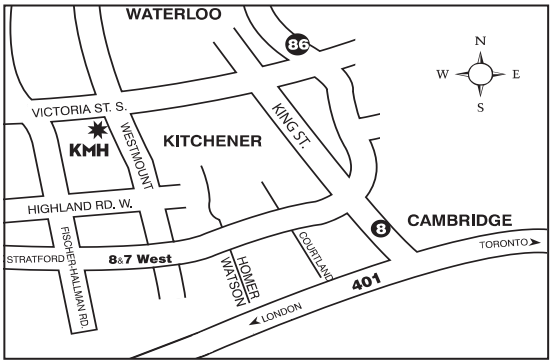
10. Completed requisitions will be assigned a protocol by KMH's radiologist. The patient will be contacted to book the appointment. Once the appointment has been made, KMH will notify your office regarding the time and date.

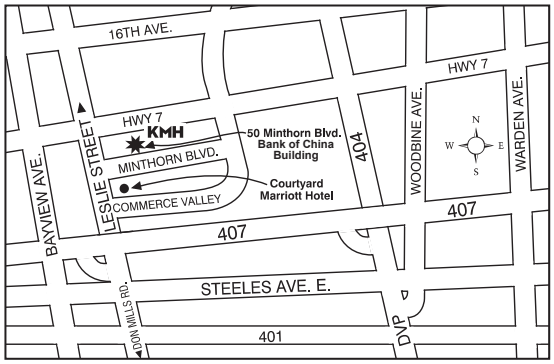
FOR ANY ABDOMEN OR PELVIC STUDIES:
1. No food or drink 8 hours prior to the appointment.
2. Some studies require you to drink an oral contrast. Please arrive 1 hour prior to the appointment time. MRI scan will follow 45-60 minutes after you drink the contrast.

FOR ANY STUDIES REQUIRING IV CONTRAST (GADOLINIUM):
1. If you have known renal diseases or are on dialysis, an eGFR/serum creatinine blood test must be done within 12 weeks prior to the appointment.

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

Maps Not To Scale





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***Urgent Requests: Urgency at discretion of the Radiologist.**

MRI'S at KMH are only performed on patients who are 12 years of age or older and with a maximum weight limit of 300lbs.