Hamilton Health Sciences

REQUEST FOR MRI CONSULTATION

Patient's Last Name | First Name

Address – Street | City | Postal Code

Telephone: ( ) | Ext.

Cell Phone: ( )

Date of Birth (yyyy/mm/dd) | Age | Gender ☐ M ☐ F

HIN | Family Physician

REQUEST TO: ☐ HGH ☐ JHCC ☐ MUMC/MCH (Peds Only)

(Site legend and contact information on back of form)

Date (yyyy/mm/dd) ______________ **Patient's Weight** __________ kg

REFERRING PHYSICIAN ____________________

PHYSICIAN SIGNATURE ____________________

Phone ________________ (ext) ______ Fax ________________

ADDRESS: ________________________________ OHIP Billing Number ______________

Exam Requested: (be specific) ________________________________

Clinical Information / Relevant History: ________________________________

- **Known Renal disease?** ☐ No ☐ Yes →
- **Known Diabetes?** ☐ No ☐ Yes →

Please fax current (within the past 3 months) bloodwork results of eGFR & Creatinine

Current Patient Location: ☐ Outpatient **OR** ☐ Emergency ☐ Inpatient - Ward/Unit ______________

- Is patient able to provide consent? ☐ No ☐ Yes

(if no) → Person to contact for consent ______________

- Has patient had a previous:

	No	Yes
MRI	☐	☐
CT	☐	☐
Ultrasound	☐	☐

(If yes to any, and if the test was performed at a location other than HHS or SJHH, please send report with this referral)

Special considerations required for this patient: ● ☐ General Anesthetic

- Is patient claustrophobic and requires sedation? ☐ No ☐ Yes → Please provide oral
- Please list any mobility restrictions: ________________________________

Patient Pre-Magnet Entry Safety Screening Questions

Does patient have any of the following:	No	Yes
● Heart pacemaker / defibrillator?	☐	☐
● Brain aneurysm clip?	☐	☐
● Spine Neurostimular?	☐	☐
● Body jewelry, piercings, or tattoos? ***(Ensure piercings are free of jewelry)***	☐	☐
● Ear implants (excluding hearing aids)?	☐	☐
● Ear tubes (if yes, which hospital were they inserted at ______________)	☐	☐

	No	Yes
Has patient ever had a metallic foreign body in their eye?	☐	☐
If yes – was it removed?	☐	☐
Is patient pregnant or breastfeeding?	☐	☐
Does patient have other implanted device(s) or surgeries?	☐	☐

If yes - Details: (type of implant or surgery, year of procedure, etc.)

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Site Legend and Contact Information

HGH = **Hamilton General Hospital**
237 Barton St. E.
Hamilton, Ontario L8L 2X2

Outpatient → Phone: 905-521-2100 Ext 46061 Fax: 905-523-6241

Inpatient → Phone: Extension 46050 Fax: 905-577-8020

After Hours (Monday to Friday 1800-0800, weekends and statutory holidays)
Page Radiologist on call through central paging

JHCC = **Juravinski Hospital & Cancer Centre**
711 Concession St.
Hamilton, ON L8V 1C3

Outpatient → Phone: 905-521-2100 Ext 41484 Fax: 905-387-8813

Inpatient → Phone: Extension 42791 Fax: 905-381-7036

After Hours (Monday to Friday 1800-0800, weekends and statutory holidays)
Page Radiologist on call through central paging

MUMC/MCH = **McMaster University Medical Centre & Children's Hospital**
1200 Main St. W.
Hamilton, ON L8N 3Z5

Outpatient → Phone: 905-521-2100 Ext 75502 Fax: 905-521-5057

Inpatient → Phone: 905-521-2100 Ext 75059/73206 Fax: 905-577-8350

After Hours page on-call pediatric radiologist Pager 76443

✳ All referrals are routed through a central booking office and reviewed by a radiologist to ensure the requested site is the most appropriate for both the patient and the requested investigation intent of the MRI and following review, the appointment will be booked at the most appropriate site which may differ from the original requested site.