Saskatchewan
Health Authority

Patient Label

NAME: _____

HSN: _____

D.O.B.: _____

❑ RUH ❑ SCH ❑ SPH ❑ Other _____

INPATIENT MRI REQUISITION

Ward/Unit: _____ Phone: _____ **Fax to: RUH – 6301 SCH – 8787 SPH – 5404**

If an **EMERGENT** MRI is required, consult the MRI radiologist through site switchboard

Date requisition completed:	❑ Emergent ❑ Urgent ❑ Semi-urgent ❑ Elective	
Examination requested (body part):	❑ Left ❑ Right	**Relevant previous exams:** ❑ MR _____ ❑ CT _____ ❑ X-ray/Mammo _____ ❑ Nuc. Med. _____ ❑ Angio _____ ❑ Ultrasound _____
Clinical question to be answered:	**Neurosurgery only** **Fiducial markers required:** ❑ Yes ❑ No **Fiducial markers placement:** ❑ Anterior ❑ Posterior **OR date:** _____	
Relevant clinical history/presumptive diagnosis:		**Relevant surgical history and date:**

Safety Screening: MRI Exams will **NOT** be booked unless the following sections are completed.
Please review with the patient – do they have any of the following:

YES	NO		YES	NO	
		A Cardiac pacemaker or pacing leads			Is the patient PREGNANT? ▶ **If yes,** what is the patient's LMP _____
		A medical implanted device (pumps, implants, etc.)			Is the patient claustrophobic? ▶ **If yes,** does the patient require: ❑ General ❑ Ativan
		Aneurysm clip			
		A metallic foreign body			The ability to lie perfectly still for a minimum of 45 min. ▶ **If no,** is sedation required? ❑ General ❑ Ativan
		A known history of metallic fragments in the eye(s) ▶ **If yes,** have orbital x-rays been completed?			
		Does the patient require physiological monitoring during the MRI? ▶ **If yes,** must be booked with SPEC anesthesia team			**Other concerns regarding MRI safety or compatibility?**

Referring/Ordering physician (print):	**Physician signature:**
Attending physician (print):	
Outpatient follow-up physician (print):	

INCOMPLETE/ILLEGIBLE REQUESTS WILL BE RETURNED/FAXED BACK WITHOUT AN APPOINTMENT

FOR DEPARTMENTAL USE ONLY

Radiologist to complete	**Priority Rating** 1 2 3 4	❑ A.M. ❑ P.M. ❑ Contrast required
Radiologist (print):	❑ Approved ❑ Rejected	
RIS MRI Exam names/codes:		

PLEASE SEE NEXT PAGE ➡

INPATIENT MRI REQUISITION

Patient Label

NAME: _____

HSN: _____

D.O.B.: _____

Fax to: RUH – 6301 SCH – 8787 SPH – 5404

Ward/Unit: _____ Phone: _____

Mobility: ❑ Walking ❑ Wheelchair ❑ Stretcher/Bed **Weight:** _____ **kg** **Height:** _____ **cm**

Precautions: ❑ Contact ❑ Airborne ❑ Droplet ❑ Cytotoxic ❑ Airway

MRI PATIENT SAFETY SCREENING QUESTIONNAIRE

The following items may be harmful to you during your MRI scan or may interfere with the MRI examination.

Please provide a 'Yes' or 'No' answer for every item.

Chest, Heart, Abdomen, Pelvis

Yes	No	
❑	❑	**Cardiac pacemaker**, ICD (defibrillator), pacemaker leads/wires
❑	❑	**Cardiac stent**, heart valve, vessel coil, or IVC filter
❑	❑	**Tissue expander** (i.e., breast)
❑	❑	Colonoscopy or gastroscopy? If **yes**, was a polyp removed? ❑ Yes ❑ No If yes, how? _____
❑	❑	IUD, penile implant
❑	❑	**Drug pump** (internal or external)
❑	❑	Surgical clips, staples, mesh
❑	❑	Vessel stents

Head, Brain, Neck, Spine

Yes	No	
❑	❑	**Aneurysm clips/coils**, carotid stent
❑	❑	Intraventricular drain, VP shunt, **ICP monitor**
❑	❑	**Deep brain stimulator, neurostimulator**
❑	❑	Artificial eye or eyelid spring
❑	❑	Eye injury from metal shavings/slivers
❑	❑	Ear implant
❑	❑	Hearing aid(s)
❑	❑	Spinal fusion, discectomy
❑	❑	Other items: _____

Other

Yes	No	
❑	❑	Metal pins, rods, screws, plates, joint replacement
❑	❑	Injured by metal object (shrapnel, bullet, BB)
❑	❑	IV access or port
❑	❑	Dentures, braces
❑	❑	Body piercing, tattoo, permanent makeup
❑	❑	Medication patch (nitro, nicotine, contraceptive, estrogen, silver nitrate dressing, etc.)
❑	❑	Wig, extensions
❑	❑	Are you **claustrophobic**? If **yes**, do you require sedation for the procedure? ❑ No ❑ Yes
❑	❑	Are you in significant pain?
❑	❑	Previous **allergic reaction** to MRI contrast (Gadolinium)?

Female Patients

Yes	No	
❑	❑	Are you **pregnant**?
❑	❑	Are you breastfeeding?

Do you have a history of:

Yes	No	
❑	❑	Previous reaction to MRI IV contrast?
❑	❑	Protein in your urine or gout?
❑	❑	Kidney disease or serious kidney injury/surgery?
❑	❑	Kidney dialysis?
❑	❑	Liver disease?
❑	❑	Diabetes?
❑	❑	High blood pressure?

Completed by (signature):

Patient/Guardian _____

and/or

Nurse/HCP _____

Date: _____

2nd screen by MRI technologist: _____

Inpatient Code Status confirmed: ❑ Yes ❑ No

Creatinine lab result:

Date _____

Serum creatinine (µmol/L) _____

eGFR (mL/min/1.73m²) _____

NOT FILED ON PERMANENT HEALTH RECORD