Saskatchewan
Health Authority

☐ RUH ☐ SCH ☐ SPH ☐ Other _____

OUTPATIENT MRI REQUISITION

Please complete, sign, and return or fax to MRI Central Bookings at RUH (306-655-2416).
If an **emergent** MRI is required, consult the MRI radiologist: RUH 306-655-2412, SCH 306-655-8123, SPH 306-655-5140 Afterhours: Switchboard

Site preference: ☐ RUH ☐ SCH ☐ SPH ☐ First available MRI Central Booking phone #: 306-655-2412

Last name: _____
Given name: _____
Date of birth: Day _____ Month _____ Year _____
Provincial health services #: _____
Phone #: H (___) _____ W (___) _____
Address (in full): _____
_____
_____
Postal code: _____

Referring physician: _____
Referring specialty: _____
Physician's phone #: _____
Physician's fax #: _____
Extra report to: _____
Fax #: _____

Health record #: ☐ RUH _____
☐ SCH _____
☐ SPH _____

☐ Wheelchair ☐ Stretcher ☐ Ambulatory ☐ Mechanical lift

What is the clinical priority of this examination?
☐ Elective ☐ Semi-urgent ☐ Urgent ☐ Emergent

If inpatient: Hospital _____
Ward _____ Phone # _____

Examination (include body part) requested: ☐ Left ☐ Right

Relevant history (history must support priority): _____
_____
_____
_____
_____
_____

Previous surgical history: _____
_____
_____

Relevant previous imaging:

STUDY	YES	NO	LOCATION OF IMAGING
CT			
Angio			
MRI			
X-rays/Mammos			
Ultrasound			
Nuc. Med.			

For the patient's **SAFETY** the MRI examination will not be booked unless this **SCREENING** section is **completed in full**.

Patient weight: _____ kg
Patient height: _____ cm

Please select **Yes** or **No** for the following:

PATIENT HAS

Yes	No	
☐	☐	A cardiac pacemaker or pacing leads
☐	☐	A medical implanted device (pumps, implants, etc.)
☐	☐	A metallic foreign body or metallic vascular clip
☐	☐	A known history of metal fragments in the eye(s)

If yes, orbital x-rays completed? _____

☐	☐	Claustrophobia
☐	☐	Ability to lie perfectly still for a minimum of 1 hour

If no, is sedation/analgesia required? ☐ Yes ☐ No
☐ SL Ativan (please provide prescription if possible)
☐ General anesthesia

☐	☐	Is pregnant **LMP** _____

For expected IV contrast studies:

☐	☐	Abnormal renal function (history of renal disease, hypertension, diabetes mellitus, gout)

If yes, serum creatinine: _____ **Test date:** _____

☐	☐	Previous reaction to MRI IV contrast

Other concerns regarding MRI compatibility/safety: _____
_____

Signature of ordering physician: _____ **Print name:** _____

DEPARTMENT USE ONLY

Date/Time received: _____ ☐ PM ☐ Contrast required Priority rating: 4 3 2 1
☐ Approved ☐ Rejected – reason _____ ☐ More information required _____
Radiologist: _____ Booked date/time: _____
Reservation #: _____

RIS MRI exam names/codes:

Radiologist imaging protocol: _____
_____
_____ ☐ MD check _____ RAD/RES