Lakeridge Health Request for MR

☐ **AJAX-PICKERING**
580 Harwood Avenue South
Ajax, ON L1S 2J4
Phone: 905-721-4717
Fax: 905-428-5243

☐ **OSHAWA**
1 Hospital Court
Oshawa, ON L1G 2B9
Phone: 905-721-4717
Fax: 905-721-4870

Outpatient requests will be given first available at any department unless specified

☐ Outpatient ☐ Inpatient ☐ ED | loc. _____

PATIENT INFORMATION

Name _____ (*Last name, First name*) Date of birth _____ (*Day-Month-Year*) Sex ☐ M ☐ F ☐ Other

Health card _____ Version code _____ Hospital ID _____

Address _____

City _____ Postal code _____ Phone 1 _____ (*Preferred*) Phone 2 _____ (*Alternate*)

SCREENING

NEPHROPATHY

Hemodialysis ☐ Y ☐ N
If yes and receiving gadolinium, dialysis must be arranged same day

Peritoneal dialysis ☐ Y ☐ N
If yes and receiving gadolinium, prescription may need alteration

PRECAUTIONS - *completed with patient*

Patient height/weight _____ cm _____ kg

Worked with metal ever (e.g. grinding, welding) ☐ Y ☐ N

Previous eye injury involving metal ☐ Y ☐ N
If yes, orbits x-ray report must be attached

Claustrophobia requiring sedation ☐ Y ☐ N
If yes, referring physician to provide sedation

Chance of pregnancy ☐ Y ☐ N

Requires mobility assistance ☐ Y ☐ N

Does patient have:

- Pacemaker, defibrillator, implanted cardiac leads ☐ Y ☐ N
- Cochlear (ear) implant ☐ Y ☐ N
- Aneurysm clips, coils, or stents ☐ Y ☐ N
- Artificial heart valve ☐ Y ☐ N
- Infusion pump or neurostimulator ☐ Y ☐ N
- Any other surgical implantable device/prosthesis ☐ Y ☐ N
- Shrapnel/bullets ☐ Y ☐ N

Manufacturer and model number of implantable devices required

Any previous surgery to ears, eyes, brain, or heart ☐ Y ☐ N

Any medical procedure or surgery in last 6 weeks ☐ Y ☐ N

Provide details of precautions (and attach relevant operative notes):

REQUESTED PRIORITY

☐ Routine ☐ STAT/Urgent | ☐ Specific date _____

REGION TO BE EXAMINED

CLINICAL INDICATION/RELEVANT HISTORY

Relevant previous imaging reports must be attached

INTERNAL USE

Priority ☐ 1 ☐ 2 ☐ 3 ☐ 4 | ☐ Timed _____

CCO ☐ Breast screen ☐ Cancer ☐ Other | ☐ Rad review

☐ MRT review _____ ☐1.5 ☐3 ☐A

BILLING

☐ OHIP ☐ WSIB claim # _____ ☐ Other _____

REFERRING PHYSICIAN

Name, address, fax, phone, billing number:

Send copies to:

Patient (or SDM) Signature ✗ _____ Signature ✗ _____ Date _____