St. Thomas Elgin General Hospital

For APPOINTMENTS, CALL (519) 631-2020 Ext: 2736
Mon-Fri Only Between 8:00AM-5:00PM
FAX: (519) 631-8842

Please Note: This form is to be used for outpatient requests only. Please ensure all fields are completed and attach MRI screening forms (when applicable) to avoid delays in patient processing.

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL

ADDRESS	CITY	PROVINCE	POSTAL CODE

CELL PHONE	ALTERNATIVE PHONE	EMAIL

Patient consents to appointment information being disclosed to them via text or e-mail ☐ Yes, text ☐ Yes, e-mail

BIRTH SEX ☐ Female ☐ Male	GENDER IDENTITY ☐ Female ☐ Male ☐ Other:	DOB (YYYY/MM/DD)	HEIGHT (CM)	WEIGHT (KG)

HEALTH CARD NUMBER	VERSION CODE:	WSIB CLAIM NO.	OTHER (self-pay, research, 3rd party payer)

☐ INTERPRETER REQUIRED Preferred Language:	MOBILITY REQUIREMENTS

EXAM INFORMATION AND HISTORY

TEST/REGION TO BE EXAMINED (Choosing Wisely checklist MUST accompany referrals where appropriate i.e. knee)

REASON FOR EXAM/CLINICAL HISTORY

SCREENING & PRECAUTIONS (Please answer all of the following questions)

NEPHROPATHY

Impaired renal function? ☐ Yes ☐ No

On dialysis: ☐ Yes ☐ No

If the answer to any of the above question(s) is yes, please provide eGFR or Creatinine results within 6 months:

eGFR (ml/min/1.73^2)

DATE (YYYY/MM/DD)

Creatinine

DATE (YYYY/MM/DD)

Is the patient claustrophobic?	☐ Yes	☐ No
Does the patient require oral sedative prescribed by requesting physician?	☐ Yes	☐ No
Known allergy to MRI contrast agent?	☐ Yes	☐ No
Chance of Pregnancy?	☐ Yes ☐ No	☐ Unknown

POSSIBLE MRI CONTRAINDICATIONS:

- ☐ Cardiac pacemaker or defibrillator
- ☐ Prior metal fragment
- ☐ Eye surgery/injury (excl. lens implants, cataract, or laser surgery)
- ☐ Ear surgery/implant (excl. ear tubes)
- ☐ Implanted stimulators or electrodes
- ☐ Any filters, stents, coils, grafts, valves, or programmable shunts
- ☐ Aneurysm surgery
- ☐ Weight is above limit (Max WT: 250kg/551lbs)
- ☐ None of the above

Please provide operative report and specify the device information below (include as much detail as possible):

MAKE: **MODEL NO.**

INSTITUTION WHERE TREATMENT WAS RECEIVED: **DATE (YYYY/MM/DD):**

REFERRING PROVIDER

NAME	BILLING NO.	LICENSE NO.

ADDRESS	CITY	PROVINCE	POSTAL CODE

PRIMARY PHONE	URGENT FINDINGS PHONE	COPY TO

PROVIDER SIGNATURE	DATE

OFFICE USE ONLY

PRIORITY ☐ P1 ☐ P2 ☐ P3 ☐ P4	TIMED: ☐ Yes ☐ No	SPECIFIED DATE:

CCO: ☐ Yes ☐ No	PROTOCOL:	RADIOLOGIST: