3045 Baseline Road
Nepean, Ontario
K2H 8P4

All Diagnostic Imaging Bookings
Call: 613-721-4711
Fax: 613-721-4771

DIAGNOSTIC IMAGING
SPECIALIZED IMAGING REFERRAL FORM
(C.T. SCAN, MRI, NUCLEAR MEDICINE)

Please complete all sections and SIGN.
Requisition is required to preform any diagnostic test
Referral forms with insufficient clinical information will be returned

WSIB

Name of employer:
Address of employer:
Date of accident:
Social insurance No.
Claim No.:

C.T. / MRI REQUESTS

Head: _____

Spine: _____

Body: _____

MSK: _____

Other: _____

Max weight 170kg (162cm girth)

MRI PATIENT SCREENING
(must be completed to be booked)

YES	NO	CLINICAL INFORMATION
☐	☐	Cardiac Pacemaker
☐	☐	Cardiac Defibrillator
☐	☐	Heart Valve Prosthesis
☐	☐	Intacranial aneurysm clip
☐	☐	Intraocular (eye) implant
☐	☐	Intraocular (eye) foreign object
☐	☐	Cochlear (ear) implant
☐	☐	Neurostimulator (tens) implant
☐	☐	Tattoos; body piercings
☐	☐	Aortic clips/stents/Stents/Shunts
☐	☐	I.U.D./Penile implant
☐	☐	Claustrophobia
☐	☐	Grinder/Welder/Metal worker

Max weight 170kg

NUCLEAR MEDICINE REQUEST

- ☐ Bone Scan
- ☐ Breast Scan (Sentinel node Injection)
- ☐ Gallium Scan
- ☐ Kidney Scan (differential)
- ☐ Kidney Scan (diuretic)
- ☐ Kidney Scan (captopril)
- ☐ Thyroid Scan
- ☐ Liver Scan
- ☐ Lung Scan
- ☐ Meckel's Scan
- ☐ LV Gated Scan (MUGA)
- ☐ Cardiac Scan (persantine)
- ☐ Cardiac Scan (exercise)
- ☐ H.I.D.A. Scan
- ☐ Other _____

Max weight 158kg

The following information must be provided prior to test being scheduled

	Yes	No
Pregnant/Breast Feeding	☐	☐
Allergy to Iodine	☐	☐
Diabetic on Metformin/Glucophage/Avandia Met	☐	☐
Does your patient have kidney problems or a kidney transplant?	☐	☐
Has your patient seen or are they waiting to see a nephrologist or urologist?	☐	☐

Creatinine **Glomerlar Filtration Rate (GFR)**

IMPORTANT PATIENT INFORMATION ON OTHER SIDE
(CLINICAL INFORMATION IS MANDATORY)

Clinical Information /Reason for test:

Referring Physician: PLEASE SIGN AND PRINT

OHIP Billing #

Copy report to Physician: **PLEASE PRINT**

Protocol (Dep use only)

As discussed with

_____
Radiologist's Name

Isolation Precautions

☐ **Yes** ☐ **No**

- ☐ Contact
- ☐ Airborne
- ☐ Droplet

Thank you for allowing us to service your Diagnostic health care needs!

RADI 187-24-05