Two centres ...*one team!*

Fax: 819-420-0134 **Fax: 819-777-7718**

For office use:

Physician Referral Form

Full Name: ______________________ D.O.B.: ______________________
/Yr /M /D

Address: ____

Tel.(h): ______________________ Tel.(other): ______________________

Allergies: ______________________ Weight: ____________ Height: ____________

Area to be Scanned

Head/Brain
- ❑ Head
- ❑ Sinuses
- ❑ Orbits
- ❑ IAC
- ❑ Pituitary Gland
- ❑ TMJ

Details______________

Spine
- ❑ Cervical
- ❑ Thoracic
- ❑ Lumbar
- ❑ Sacroiliac Joints
- ❑ Brachial Plexus
- ❑ Neck

Details______________

Breasts (both)
- ❑ Evaluation and staging
- ❑ Integrity of implants

Chest/Abdomen
- ❑ Chest
- ❑ Abdomen
- ❑ Pelvis
- ❑ MRCP

Region of Interest______________

Musculo-Skeletal/Joints
- ❑ Upper Extremity

Details ______________
- ❑ Lower Extremity

Details ______________
- ❑ Other

Details ______________

Clinic Preference?*
- ❑ Ottawa Valley MRI
- ❑ St-Joseph MRI

Radiologist Preference?*

____

* *will be honored as much as is possible*

Language of Report?
- ❑ English
- ❑ French

Previous Exams?
- ❑ MRI
- ❑ CT
- ❑ X-rays
- ❑ U/S
- ❑ Nuclear Medicine
- ❑ PET

Copy of Report to?

Mandatory **clinical information and presumptive diagnosis:**

Preliminary Screening

important - please check if applicable

The patient has a(n):
- ❑ Aneurysm clip*
- ❑ Neurostimulator
- ❑ Cochlear implants/tube in ears**
- ❑ Vascular stent or vena cava filter**
- ❑ Cardiac pacemaker
- ❑ Tatoo or body piercing
- ❑ Transdermal patch

* *these patients generally cannot be imaged by MRI in our setting*

** *If yes, please provide operative report*

The patient has had previous:
- ❑ Cardiac surgery
- ❑ Brain surgery

Details: ______________

The patient suffers with:
- ❑ Claustrophobia
- ❑ Kidney failure
- ❑ Hypertension
- ❑ Cardiovascular problems
- ❑ Diabetes

The patient has :
- ❑ worked as metal worker, grinder or welder*
- ❑ a chance of metallic fragments in the eyes*
- ❑ a chance of being pregnant

* *If yes, please provide orbital x-ray report*

For radiologist use:

Ordering Physician: ______________________ Signature: ______________________

Date: ______________ Tel: ______________ FAX: ______________________

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