Hôpital Régional de Pembroke Regional Hospital

Diagnostic Imaging (DI) Requisition

Addressograph

PRH Telephone Number: (613) 732-4141, PRH DI MAIN Fax Number: (613) 732-6349
Computed Tomography (C.T.) & Nuclear Medicine Fax Number: (613) 633-4579

Examination(s) Requested:

Precautions:
☐ Contact ☐ Droplet ☐ Airborne ☐ Mask/Shield

Location of Patient:

Patient History and Pertinent Lab Results:

Mode of Transportation (In-Patients):
☐ wheelchair ☐ stretcher ☐ bed
☐ ambulatory ☐ portable ☐ fall risk

Oxygen required:
Yes No
☐ ☐

Patient Weight (kg)	**Patient Height (cm)**	**Allergies:**

Y	N	**Please check the following if applicable**
☐	☐	Renal impairment
☐	☐	Family history of End Stage Renal Disease
☐	☐	Dialysis Treatment
☐	☐	Metformin Treatment
☐	☐	Pregnant Beta-hCG level:

Y	N	**Contrast Nephropathy Risk Factors**
☐	☐	Diabetes Mellitus
☐	☐	Cardiac Disease
☐	☐	Hypertension
☐	☐	Nephrotoxic drugs:
☐	☐	Immunosuppression:
☐	☐	Collagen vascular disease
☐	☐	Dehydration, sepsis, shock

Y	N	**Possible MRI Contraindications**
☐	☐	Aneurysm surgery
☐	☐	Intraocular lens implant/Prior metal fragment
☐	☐	Eye surgery (excluding lens implants, cataract or laser)
☐	☐	Ear surgery (excluding ear tubes)
☐	☐	Cardiac Pacemaker
☐	☐	Implanted stimulators, electrodes, electronic devices
☐	☐	Any filters, stents, coils, grafts or shunts

Bone Density (BMD)
☐ Baseline (first BMD in Ontario)
☐ 2nd Low Risk (at 36 Months)
☐ 3rd Low Risk (at 60 Months)
☐ High Risk (once every 12 Months)

Creatinine Clearance or eGFR required for patients with ≥1 contrast nephropathy risk factors. Please provide the most recent value, date (within 3 months), and location of the test. Report required if not performed at PRH.

Location:

Cr level:	eGFR level:	Date of test:

MRI is contraindicated for all patients with pacemakers or defibrillators. Please forward operative report and specify the (stickers of make and model).

Device:	Date:	Institution of Surgery:

Breast Imaging:
Implants: ☐ Yes ☐ No
Last mammogram:
Date: Location:

Ordering Practitioner (Print):
Signature:
Billing Number:

Office Telephone Number:
Fax Number:
Pager Number:

Copy of report to:
Address:
Fax Number:

OFFICE USE ONLY

Protocol:

Priority Code	**Protocolled by**	**eGFR Required?** ☐ **Yes** ☐ **No** ☐ **1m** ☐ **3m**	**Appointment Date:** **Time:**

Form # 584187