BERMUDA HEALTHCARE SERVICES

19 THE LANE
PAGET PG 05
BERMUDA

PHONE: 441-236-2810
FAX: 441-236-5569
EMAIL: MRITECH@BHCS.BM
WEB: WWW.BHCS.BM

MRI REFERRAL

PATIENT NAME _____ DATE _____

PATIENT ADDRESS _____

PHONE (C)_____ (W)_____ (H)_____

DOB (DD/MM/YY) _____ GENDER: M___ F___ EMAIL_____

APPT. DATE:_____ TIME: _____ LAHEY CLINIC # _____

INSURANCE COMPANY : _____ POLICY #: _____ CERTIFICATE: _____

HEAD

- ☐ BRAIN
- ☐ SELLA
- ☐ ORBITS
- ☐ IAMS
- ☐ OTHER _____

_____

MRA

- ☐ HEAD
- ☐ NECK

CHEST

- ☐ CHEST WALL
- ☐ MEDIASTINUM

SPINE

- ☐ CERVICAL
- ☐ THORACIC
- ☐ LUMBAR
- ☐ SACRUM
- ☐ SOFT TISSUE NECK
- ☐ OTHER _____

ABDOMEN

- ☐ LIVER
- ☐ PANCREAS
- ☐ KIDNEY
- ☐ ADRENALS
- ☐ AORTA
- ☐ OTHER _____

UPPER EXTREMITY

- ☐ SHOULDER R or L
- ☐ HUMERUS R or L
- ☐ ELBOW R or L
- ☐ FOREARM R or L
- ☐ WRIST R or L
- ☐ HAND R or L
- ☐ FINGER R or L
- ☐ OTHER _____

_____

_____

_____

_____

LOWER EXTREMITY

- ☐ HIP R or L
- ☐ FEMUR R or L
- ☐ KNEE R or L
- ☐ TIB/FIB R or L
- ☐ ANKLE R or L
- ☐ FOOT R or L
- ☐ TOE R or L
- ☐ FEMALE PELVIS
- ☐ ORTHO PELVIS
- ☐ PROSTATE / MALE PELVIS
- ☐ RUN OFF LEGS
- ☐ OTHER _____

_____

SERUM CREATININE LAB IS REQUIRED ON ALL PATIENTS NEEDING CONTRAST

CREATININE_____ DATE_____

IS THIS PATIENT ON DIALYSIS? YES ☐ NO ☐

IF YES, PATIENT SHOULD HAVE DIALYSIS WITHIN 24 HRS AFTER INFUSION OF CONTRAST.

SYMPTOMS/REASON(S) FOR MRI_____

_____

DIAGNOSIS_____ ICD-9_____ DIAGNOSIS_____ ICD-9_____

REFERRING DR._____ PHONE (O)_____ (C)_____

SIGNATURE _____ FAX_____

MRI SCREENING FORM

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Name_____ Weight_____ Height_____

Date of Birth _____ Lahey Clinic # _____ Date _____

Y or N

- ☐ ☐ Have you ever worked with welding, metal grinding or brakes?
- ☐ ☐ Have you ever had a penetrating injury to your eye involving a metallic object? __L __R
- ☐ ☐ If metal was in your eye, was it removed by a doctor?
- ☐ ☐ Do you have tattoos or permanent eyeliner?
- ☐ ☐ Do you have ocular implants?
- ☐ ☐ Are you currently pregnant or breast feeding?
- ☐ ☐ Have you had the following? *(Check those that apply)* __Cardiac pacemaker __Pace wires __Cardiac catheter __Cardiac loop recorder
- ☐ ☐ Implanted cardiac defibrillator (ICD)?
- ☐ ☐ Cardiac stent (within last 4 weeks)?
- ☐ ☐ Brain Surgery? When?_____ Where?_____ Type?_____
- ☐ ☐ Brain aneurysm clip(s)? When?_____ Where?_____
- ☐ ☐ Carotid artery vascular clamp? When?_____ Where?_____
- ☐ ☐ Cochlear and/or stapes implant? When?_____
- ☐ ☐ Shunt (intraventricular or spinal)?
- ☐ ☐ Intravascular stents, fillers or coils (within last 4 weeks)?
- ☐ ☐ Insulin or infusion pump (internal/external)?
- ☐ ☐ Bone growth/fusion stimulator?
- ☐ ☐ Neurostimulators (deep brain vagus nerve or bladder stimulators)?
- ☐ ☐ Any prosthesis (penile, artificial limb, or breast expanders)?
- ☐ ☐ Joint replacement, screws, pins, rods, staples, metal sutures, mesh implants?
- ☐ ☐ Do you have *(Check those that apply)* __Hearing aid (external or implanted) __Magnetic dentures __Transdermal patch
- ☐ ☐ Swan Ganz Line (Internal only)?
- ☐ ☐ Do you have any shrapnel (bullets) in your body?
- ☐ ☐ Do you have Claustrophobia? If yes, are medications ordered for this?
- ☐ ☐ Do you have asthma or allergies? Have you had a previous reaction to MRI Contrast (Gadolinium)?
- ☐ ☐ Are you on Dialysis?
- ☐ ☐ Do you have connective tissue disorder?
- ☐ ☐ Small bowel endoscopy capsule?

Signature of PATIENT or Guardian:_____ Date_____

Please fax this screening form along with the MD order and reason for exam to MRI at 236-5569.