BERMUDA HOSPITALS BOARD

KING EDWARD VII MEMORIAL HOSPITAL

DIAGNOSTIC IMAGING DEPARTMENT

MRI REQUISITION

Please Arrive 30 minutes prior to scheduled time, or your exam may be rescheduled.

Surname: ______________________ **Chart #:** ______________________

First Name(s): ______________________ **DOB:** ______________________

Physician: ______________________ **Patient Weight:** ________ **lbs.**

Contraindications:

Does the patient have any of the following:

Pregnant? Yes No

Pacemaker? Yes No

Aneurysm Clip? Yes No

Cochlear Implant? Yes No

Any type of defibrillator or stimulator? Yes No

Any other metal or surgical implants? Yes No

If yes, please explain. ______________________

Has the patient ever worked with metal or metal fragments (e.g. welding, grinding, etc)? Yes No

Has the patient had surgery in the last 6 weeks? Yes No

If yes, please explain. ______________________

Does the patient have any renal problems or Sickle Cell disease? ______________________

For spine requests, specify duration of symptoms, side affected, and clinical nerve root level.

History / Reason for Exam:

Ordering Physician's Signature ______________________

Brain _____
Pituitary _____
IAMs _____
Orbit _____
Chest _____
Mediastinum _____

Abdomen:
Liver _____
Pancreas _____
Kidney _____
Spleen _____
Adrenals _____
MRCP _____
Other *(please specify)*: _____

Spine:
Cervical _____
Thoracic _____
Lumbar _____
Spinal Cord _____

Other:
TMJ _____
Neck _____
Pelvis _____
Extremities: _____
Joints: _____
Other: _____

MRA:
Brain _____
Neck _____
Chest _____
Kidney _____
Abdominal Aorta _____
Runoff Legs _____
Other: _____

E.L. S26047

Bermuda Hospitals Board
CARING FOR OUR COMMUNITY

WARD

SURNAME .... Maiden Name ....

FIRST NAMES .... D.O.B. ....

ADDRESS .... Doctor ....

....

.... Chart No. ....

DIAGNOSTIC IMAGING DEPARTMENT

PATIENT PRE-MRI SCREENING AND CONSENT FORM

Patient Weight: ________________ lbs.

Welcome to the MRI Department. In the interest of your safety and the quality of your exam please take a moment to thoroughly complete this form. Some devices may restrict you from having an MRI. Please remove and secure ***all*** loose metal objects before entering scan room e.g. jewelry, watch, hairpins, etc. If at any time you require assistance, please stop and ask for help. Thank you.

Yes No Are you or could you be pregnant? Patient Signature ____________________

Yes No Do you or have you ever had a pacemaker?

Yes No Do you have or have you ever had metal in or removed from your eye?
*If yes, have you had an MRI since? Yes No

Yes No Have you had any surgeries within the last 6 weeks?
*If yes, pleaes list all surgeries ____________________

Yes	No	Cardiac (Heart) Surgery	Yes	No	Dentures
Yes	No	Cardiac (Heart) Defibrillator	Yes	No	Shunts
Yes	No	Ear surgery or implants	Yes	No	External / Internal Insulin Pump
Yes	No	Cochlear implant	Yes	No	Currently Breast Feeding
Yes	No	Brain surgery	Yes	No	IUD
Yes	No	Aneurysm repair or implants	Yes	No	Diabetic
Yes	No	Metal implants/plates/screws/nails	Yes	No	Kidney Disease
Yes	No	Prosthesis (penile, eye, etc.)	Yes	No	Sickle Cell Anemia
Yes	No	Bone or Neuro Stimulator	Yes	No	Other metal not mentioned
Yes	No	Tattoos			
Yes	No	Body piercing	Yes	No	Drug Allergies
Yes	No	Hearing Aid			____________________

At your convenience, please visit the restroom before entering the scan room.
A contrast agent (Gadolinium) is sometimes required on MRI exams. The Radiologist and your Physician will determine the need for administration of this contrast. I have read, answered and understood the above information to the best of my knowledge. I hereby give consent to undergo this examination.

____________________ ____________________ ____/____/____
Patient/Person Responsible for Consent Signature Today's Date

____________________ ____________________ ____/____/____
Doctor/Nurse/Technologist Signature Today's Date

Please provide the name of a family member or friend who can be contacted in the unlikely case of an emergency.

Family Member: ____________________ Tel: ____________________

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