# DIAGNOSTIC IMAGING – BREAST MRI

MRI-Breast

| | | |
|---|---|---|
| | MD Name: | Patient Name: |
| | Signature: | DOB: |
| | CPSO # : | HCN: |
| | Date: (d/m/y) | Home Phone: |
| **FAX ALL REQUISITIONS TO:** | Copies to: | Cell Phone |
| **613-969-5561** | WSIB #: | Address: |

A BOOKING WILL NOT BE MADE UNLESS THIS REQUISITION IS COMPLETED IN FULL

Clinical Information: Please choose one.

- ☐ New Biopsy proven invasive lobular carcinoma
- ☐ New Biopsy proven locally advanced carcinoma
- ☐ Implant Assessment
- ☐ Previous invasive lobular carcinoma or locally advanced disease
- ☐ Mammo occult (> 75% density) biopsy proven carcinoma

☐ Pre Menopausal ☐ Post Menopausal LMP:

**Safety Questions must be completed**

| Y | N | Question | Y | N | Question |
|---|---|---|---|---|---|
| ☐ | ☐ | Have you ever had metal in your eye? If yes, orbital X-Rays are required pre MRI, unless previous MRI at Quinte Health after exposure. | ☐ | ☐ | Are you claustrophobic? If yes, please see your doctor for a sedative. |
| ☐ | ☐ | Pacemaker or Defibrillator? | ☐ | ☐ | Are you currently on dialysis? |
| ☐ | ☐ | Cochlear Implant? | ☐ | ☐ | Brain aneurysm clip? |
| ☐ | ☐ | Shrapnel or bullets? | ☐ | ☐ | Neurostimulator device? |
| ☐ | ☐ | Any implanted devices? Please specify:______________________ | ☐ | ☐ | Pregnant or breastfeeding? |

**Previous Surgeries (please list Sx with dates):**

_______________________________________________

_______________________________________________

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**DEPARTMENT USE ONLY**

**Protocol:**

**Priority:** 1 2 3 4

**Time:** 15 20 25 30 35 40 45 50 55 60

☐ **Sedation** ☐ **Weekday** ☐ **Gfr** ☐ **Orbits** ☐ **Cancer Staging**

Appointment Date & Time:

Notes:

PLEASE ENSURE REQUISITION IS COMPLETE . FAX REQUISITION TO 613-969-5561

Form # 1037