**Oakville Trafalgar Memorial Hospital**

## Diagnostic Imaging Department

# INTERVENTIONAL RADIOLOGY

## Uterine Fibroid Embolization Referral and MRI Pelvis

**Incomplete/illegible requisitions will be returned resulting in delay to booking**

Mailing Address: OTMH 3001 Hospital Gate, Oakville, ON L6M 0L8
Phone: 905-338-4601 Fax: 905-845-9921

Name: ______________________ M / F / X
SURNAME, GIVEN NAME

Address: ______________________
STREET (APT)

__________ CITY __________ PROVINCE __________ POSTAL CODE

Phone: (H)__________ (W/C) __________

***Do we have your consent to leave information pertaining to your appointment?***

❒ **Yes** - Indicate phone # __________

D.O.B: ____/____/____ (DD / MM / YY) Health Card #: __________ INCLUDING VERSION CODE

Unit #: __________

**PHYSICIAN INFORMATION:**

Address: __________

Postal Code: __________

Phone: __________ Fax: __________

Copies to: __________

**CLINICAL HISTORY; DIFFERENTIAL DIAGNOSIS; SPECIFIC QUESTIONS?**

__________

__________

**List any outside relevant studies. Reports of such MUST accompany this requisition – otherwise booking will be delayed:**

__________

### Patient Past Medical History

| | Yes | No |
|---|---|---|
| Allergies to contrast: | ❒ | ❒ |
| Latex Allergy: | ❒ | ❒ |
| Other allergies: __________ | | |
| Renal Disease: | ❒ | ❒ |
| Significant cardio-pulmonary disease: | ❒ | ❒ |
| History of diabetes: | ❒ | ❒ |
| History of excessive bleeding: | ❒ | ❒ |

### Patient Medications

| | Yes | No |
|---|---|---|
| Aspirin: | ❒ | ❒ |
| Metformin (Glucophage): | ❒ | ❒ |
| Antibiotics: __________ | ❒ | ❒ |
| Anti-coagulants: __________ | ❒ | ❒ |
| Anti-platelet drug: __________ | ❒ | ❒ |
| Anti-inflammatory drug: __________ | ❒ | ❒ |
| Is the patient able to sign consent? | ❒ | ❒ |

*H4412*

***Physician Signature:***

__________

**Please Print Name:** __________

## MRI Patient Safety Screening Questions

**All must be answered or request will be returned**

| | Yes | No |
|---|---|---|
| 1. History of orbital injury by metal requiring medical attention? If metal not clearly removed – obtain orbital radiographs. | ❒ | ❒ |
| 2. Is the patient claustrophobic? If "Yes", consider prescription for PRN medication (we do not provide). If Rx provided, patient must be accompanied. | ❒ | ❒ |
| 3. Are there other potential difficulties? Describe __________ | ❒ | ❒ |
| 4. Pregnancy status: If "Yes" or unclear at the time of exam, the study may be deferred. | | |
| 5. Do you have any of the following: | | |
| • Cardiac Pacemaker.................................... | ❒ | ❒ |
| • Artificial Cardiac Valve.................................... | ❒ | ❒ |
| • Retained Pacing Wires.................................... | ❒ | ❒ |
| • Brain Aneurysm Clips.................................... | ❒ | ❒ |
| • Neurostimulator .................................... | ❒ | ❒ |
| • Cochlear (ear) Implants .................................... | ❒ | ❒ |
| • Shrapnel / Bullets.................................... | ❒ | ❒ |
| • Metal rods, plates, screws, wires.................................... | ❒ | ❒ |
| • List any Implanted Devices: __________ | | |

6. Type and date of <u>ALL</u> surgeries and any implanted devices from procedures:

__________

__________

__________

7. Patient's WEIGHT: __________ lbs. (Maximum of 550 lbs.)

Is an Interpreter required? Yes ❒ Sign Language Interpreter? Yes ❒

NOTE: If the patient is unable to speak English, he/she must be accompanied by a translator or interpreter for the whole duration of the appointment

**APPOINTMENT DATE:**

**Day:** __________ **Month:** __________ **Year:** __________ **Time:** __________