UNIVERSITY OF OTTAWA HEART INSTITUTE
INSTITUT DE CARDIOLOGIE DE L'UNIVERSITÉ D'OTTAWA

# Cardiac Diagnostic Imaging Requisition
# CT, MRI, X-RAY


**Booking / Information / Cancellations**
**Phone: 613-696-7066** **Fax: 613-696-7098**
40 Ruskin Street, Ottawa ON K1Y 4W7
www.ottawaheart.ca


Medical record number

**PRIORITY:** ❑ **Inpatient** – Ward: ❑ **Outpatient** – Urgency: ❑ less than 2 weeks
*For CT and MRI:* ❑ *Urgent* ❑ *Next working day* ❑ less than 1 month ❑ Elective

| Surname | First name | Maiden name | |
|---|---|---|---|
| Date of birth /YY /MM /DD — Gender: M ❑ F ❑ | Provincial Insurance number | Version code | Expiry date |
| Address | City | Province | Postal Code |
| Telephone number: (Home): (Alternative): | Research ❑ No ❑ Yes – Specify study name: | | |

## EXAMINATION(S) REQUESTED

For Inpatients (mode of transportation):
❑ Bed ❑ Stretcher ❑ Wheelchair
❑ Ambulatory ❑ Portable

## CLINICAL INFORMATION

**REASON FOR REQUEST:** Please send copies of relevant report for studies requested.

❑ Chest Pain ❑ Post PCI / CABG
❑ Dyspnea ❑ History of MI
❑ Syncope ❑ Stroke / TIA
❑ Arrhythmia ❑ Heart Function / Failure

Cardiology Consult Request? ❑ Yes ❑ No

Creatinine or eGFR: _____ Date of test result: _____

Height: _____ cm Weight: _____ kg

Dialysis? ❑ Yes ❑ No Renal impairment? ❑ Yes ❑ No
Diabetic? ❑ Yes ❑ No At risk of heart failure? ❑ Yes ❑ No
Metformin? ❑ Yes ❑ No If yes, hold Lasix? ❑ Yes ❑ No

**ALLERGIES:**

**MEDICATIONS: Please list medications.**

**Possible MRI Contraindications**

MRI is contraindicated for all patients with pacemakers or defibrillators.

❑ Yes ❑ No Cardiac pacemaker/defibrillator *
❑ Yes ❑ No Aneurysm surgery
❑ Yes ❑ No Intraocular lens implant/Prior metal fragment
❑ Yes ❑ No Eye surgery (excl. lens implants, cataract or laser surgery)*
❑ Yes ❑ No Ear surgery (excl. ear tubes)*
❑ Yes ❑ No Implanted stimulators, electrodes, electronic devices *
❑ Yes ❑ No Any filters, stents, coils, grafts or shunts*

* Please forward operative report and specify the **device** | **date** | **institution** of the surgery/treatment.

| Resident's name (print) | Physician's name (print) | Physician's signature |
|---|---|---|
| Telephone no. | Fax no. | Physician's billing no. |

| Copy of report to | Family physician | Other physician(s) |
|---|---|---|

## FOR OFFICE USE ONLY

Protocol:

| Priority Code | Protocoled by | eGFR required? ❑ Yes ❑ No |
|---|---|---|

Physician Name (print): Signature:

| Comments | Physician involved | Exam time |
|---|---|---|
| | Images sent to | Technologist's signature |