VM MED

IRM/RADIOLOGIE
MÉDECINE NUCLÉAIRE ET TEP/CT
MRI / RADIOLOGY
NUCLEAR MEDICINE AND PET / CT

The only MRI center in Canada accredited by the American College of Radiology (ACR).

Canadian Association of Radiologists
L'Association canadienne des radiologistes

MRI / Radiology
1538 Sherbrooke St. W. (corner Guy)
Suite 1010 (10th floor)
Montreal, Quebec H3G 1L5
T: 514-933-4990
Fax: 514-933-4728
Email: rad@vmmed.com

PET/CT and Nuclear Medicine
2345 Guy Street (corner Sherbrooke St. W.)
Montreal, Quebec H3H 2L9
T: 514-933-5885
Fax: 514-933-4646
Email: petct@vmmed.com
www.vmmed.com

MÉTRO GUY-CONCORDIA

OPENING HOURS (May vary by department)
Monday to Thursday: 8am to 6:00pm • Friday: 8am to 5pm • Saturday and Sunday: 8:30am to 1pm

PATIENT LAST NAME: | PATIENT FIRST NAME:

REFERRING PHYSICIAN NAME: | DATE: DD / MM / YYYY

BIRTHDATE: DD / MM / YYYY TEL.: ( )

Choose your language of correspondence: ☐ English ☐ French ☐ Stat

ADDRESS: _____

TEL.: ( ) _____ FAX: ( ) _____

SIGNATURE OF REFERRING PHYSICIAN _____ LICENCE # _____

CLINICAL INFORMATION: (Required for optimal patient care)

☐ DIABETIC ☐ HYPOGLYCEMIC MEDICATIONS
☐ CNESST ☐ SAAQ File #: _____
☐ Bill the clinic (please submit billing approval form with requisition)

ALL EXAMS REQUIRE AN APPOINTMENT EXCEPT GENERAL RADIOLOGY EXAMS
For appointment cancelation, please advise us 24h in advance, as fees may be charged.

Certain or all portions of these exams are not covered by RAMQ but generally reimbursed by private insurance, SAAQ or CSST.

MAGNETIC RESONANCE IMAGING (MRI)

PLEASE COMPLETE THE MRI QUESTIONNAIRE ON THE BACK OF THIS FORM.

- ☐ Brain
- ☐ Angiogram (CoW)
- ☐ Internal Auditory Canals
- ☐ Orbits
- ☐ Temporomandibular joints
- ☐ MRI-arthrography
- ☐ Musculoskeletal ☐ L ☐ R _____
- ☐ Abdomen
- ☐ Pelvis
- ☐ Soft tissue neck
- ☐ Cervical spine
- ☐ Thoracic spine
- ☐ Lumbar spine
- ☐ Brachial plexus
- ☐ Breast
- ☐ MRI guided Biopsy (breast)
- ☐ Other: _____
- ☐ Sinus
- ☐ Thorax
- ☐ Pharynx

OUR LARGE BORE MRI UNIT IS SUITABLE FOR CLAUSTROPHOBIC PATIENTS.

PET/CT AND NUCLEAR MEDICINE - 2345 GUY ST. (514) 933-5885

PLEASE COMPLETE THE PET/CT SCAN QUESTIONNAIRE ON THE BACK OF THIS FORM.

- ☐ PET Oncology
- ☐ PET Neurology

SCINTIGRAPHIC STUDIES

- ☐ Bone
- ☐ Myocardial perfusion (MIBI)
  - ☐ Persantine ☐ Stress Test (Treadmill)
- ☐ Nuclear Ventriculography (MUGA)
- ☐ Thyroid
  - ☐ Tc99mm ☐ Iodine 123
- ☐ Parathyroids
- ☐ Renal
  - ☐ Captopril ☐ Lasix
- ☐ Hepatobiliary (HIDA)
- ☐ Gastric Emptying
- ☐ Red Blood Cells (Hemangiomas)
- ☐ White Blood Cells (Infection)
- ☐ Other: _____

CT SCAN - 2345 GUY ST. (514) 933-5885

- ☐ **CT-arthrography**
- ☐ Brain
- ☐ Internal Auditory Canals
- ☐ Virtual colonoscopy
- ☐ Neck
- ☐ Chest
- ☐ Abdomen
- ☐ Pelvis
- ☐ Spine: _____
- ☐ Musculoskeletal: _____
- ☐ Other: _____

Creatinine level: _____ (Mandatory for contrast injections)

EPIDURALS, JOINT & FACET INJECTIONS / ARTHROGRAPHY

- ☐ Arthrography _____ specify joint(s)
- ☐ Calcium lavage
- ☐ Facet injection
  - ☐ Dorsal
  - ☐ Lumbar

ULTRASOUND

GENERAL ULTRASOUND

- ☐ Abdominal (includes Renal)
- ☐ Pelvic
- ☐ Endovaginal
- ☐ Abdominal and pelvic
- ☐ Thyroid and neck
- ☐ Testicles
- ☐ Surface
- ☐ Breast ultrasound (breast ultrasounds courtesy of Breast Center)

MUSCULOSKELETAL ULTRASOUND

- ☐ Shoulder
- ☐ Knee
- ☐ Ankle
- ☐ Foot
- ☐ Elbow
- ☐ Wrist
- ☐ Hand

VASCULAR ULTRASOUND

- ☐ Transcranial and cervical/Carotid/Doppler
- ☐ Hepatic Doppler
- ☐ Renal Doppler including abdomen
- ☐ Venous Doppler / upper or lower limb
- ☐ Arterial Doppler / upper or lower limb

MAMMOGRAPHY / BREAST CENTER / BONE DENSITY

- ☐ Full Field Digital Mammography (DR) with Computer Assisted Detection (CAD)
- ☐ Breast Center: Assess patient
- ☐ Bone densitometry ☐ + Lipo

BIOPSIES

- ☐ Ultrasound-guided biopsy _____ (location)
- ☐ Stereotactic breast biopsy
- ☐ MRI-guided breast biopsy

GENERAL RADIOLOGY

HEAD AND NECK

- ☐ Skull
- ☐ Facial bones
- ☐ Maxilla
- ☐ Mastoid
- ☐ Nose
- ☐ Sinus
- ☐ Soft tissues of the neck

SPINE

- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar
- ☐ Cervical/thoracic/lumbar
- ☐ Pelvis
- ☐ SI joints
- ☐ Sacrum and coccyx

THORAX

- ☐ Lungs
- ☐ Ribs
- ☐ Sternum
- ☐ Abdomen (kidney, ureter bladder)
- ☐ Abdominal series

UPPER LIMBS

- ☐ Clavicle ☐ L ☐ R
- ☐ Acromioclavicular joints
- ☐ Shoulder ☐ L ☐ R
- ☐ Scapula ☐ L ☐ R
- ☐ Humerus ☐ L ☐ R
- ☐ Elbow ☐ L ☐ R
- ☐ Forearm ☐ L ☐ R
- ☐ Wrist ☐ L ☐ R
- ☐ Hand ☐ L ☐ R
- ☐ Sternoclavicular joint ☐ L ☐ R

LOWER LIMBS

- ☐ Pelvis ☐ L ☐ R
- ☐ Hip ☐ L ☐ R
- ☐ Femur ☐ L ☐ R
- ☐ Knee ☐ L ☐ R
- ☐ Tibia ☐ L ☐ R
- ☐ Ankle ☐ L ☐ R
- ☐ Foot ☐ L ☐ R
- ☐ Heel ☐ L ☐ R

OTHERS: _____

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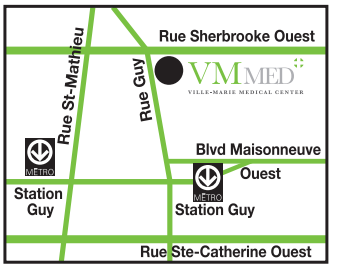

The VM Medical Radiology Center is accredited by the Canadian Association of Radiologists for mammography and is the only MRI center in Canada accredited by the American College of Radiology (ACR).

PLEASE BRING PREVIOUS IMAGES IF AVAILABLE

QUESTIONNAIRE FOR PET/CT, NUCLEAR MEDICINE, CT SCAN AND FLUOROSCOPIC GUIDED INJECTION

(to be completed by you and/or your referring physician)

Please present yourself to 1538 Sherbrooke St. W. (corner Guy), for all fluoroscopic guided injections.
Please present yourself to 2345 Guy St. (corner Sherbrooke), for all PET/CT, CT Scan, Nuclear Medicine.

Weight: _____ Height: _____

YES NO

- ☐ ☐ Pregnancy
- ☐ ☐ Breastfeeding
- ☐ ☐ Allergies / Prior reactions
  If so, which: _____
- ☐ ☐ Claustrophobic
- ☐ ☐ Diabetic Type : _____
- ☐ ☐ Prior contrast injection for CT scan, cardiac catheterization, kidney stone or MRI

GENERAL QUESTIONS:

YES NO

- ☐ ☐ Hypoglycemic medications
  Note: Patients taking Meformin (Glucophage) must discontinue use for 48 hours after iodine injection
  List any medication: _____
- ☐ ☐ Renal Failure
- ☐ ☐ Chemotherapy (date of last dose): _____
- ☐ ☐ Radiotherapy (date of last dose and irradiated area): _____

QUESTIONNAIRE FOR MAGNETIC RESONANCE IMAGING (MRI) ONLY

(to be completed by you and/or your referring physician)

Please present yourself to 1538 Sherbrooke St. (corner Guy) for all MRI exams.

ABSOLUTE COUNTER INDICATIONS

YES NO

- ☐ ☐ Pacemaker
- ☐ ☐ Neurostimulator or implanted defibrillator
- ☐ ☐ Subcutaneous implanted insulin pump
- ☐ ☐ Swan-Ganz Catheter
- ☐ ☐ Electrode fragment (post heart surgery)[1]
- ☐ ☐ Clips for cerebral, aortic, neck or any other aneurism
- ☐ ☐ Birdnest umbrella IVC filter implanted < 3 months
- ☐ ☐ Aortic stent implanted < 3 months
- ☐ ☐ Cochlear implant (inner ear)
- ☐ ☐ Magnetic ocular implant[1]
- ☐ ☐ Magnetic penile implant (OmniPhase, DuraPhase)
- ☐ ☐ Metallic fragment in the eye[1]
- ☐ ☐ Recent surgery (last 2 months) with clips or prosthesis

RELATIVE COUNTER INDICATIONS

YES NO

- ☐ ☐ Claustrophobia (fear of closed spaces)
- ☐ ☐ Pregnancy
- ☐ ☐ Weight exceeding 450 lbs.
- ☐ ☐ Metallic ventricular shunt
- ☐ ☐ Joint prosthesis / site: _____
- ☐ ☐ Fracture treated with rod, plate, screw, nails / site: _____
- ☐ ☐ Cotrel or Harrington rod(s) / site: _____
- ☐ ☐ Clips, sutures or metallic mesh / site: _____
- ☐ ☐ Shrapnel or firearm projectile / site: _____
- ☐ ☐ Previous surgery with metal / date: _____
- ☐ ☐ Breastfeeding[2]
- ☐ ☐ Medicated patch
- ☐ ☐ Medicated dressing (with Ag / silver)
- ☐ ☐ Allergies (contrast agent i.e. iodine), asthma[2]
- ☐ ☐ Iodine or Gadolinium injection in the last 48h[2]
- ☐ ☐ Renal failure (creatininemia rate _____, if over 50 years old)[2]
- ☐ ☐ Tattoo

[1] If in doubt, get X-rays of the concerned area
[2] If Gadolinium was injected

I have reviewed the above questionnaire with my physician or the imaging technologist.
The information is correct and complete and I consent to the exam.

_____ PATIENT'S SIGNATURE

_____ PHYSICIAN'S OR TECHNOLOGIST'S SIGNATURE

DD / MM / YYYY
DATE