

**RHODE ISLAND HOSPITAL CARDIOVASCULAR MR EXAM REFERRAL FORM**  
**APPOINTMENTS: (401) 444-4881**  
**FAX: (401) 444-5732**

PATIENT NAME: \_\_\_\_\_ ( M / F )      DOB: \_\_\_\_\_  
 DOES PATIENT SPEAK ENGLISH: \_\_\_\_\_ IF NOT, WHAT LANGUAGE (FOR INTERPRETER) \_\_\_\_\_  
 PATIENT PHONE:    HOME \_\_\_\_\_      WORK \_\_\_\_\_  
 PRIMARY INSURANCE NAME AND NUMBER: \_\_\_\_\_  
 SECONDARY INSURANCE NAME AND NUMBER: \_\_\_\_\_  
 TODAY'S DATE: \_\_\_\_\_

DESIRED EXAM DATE:  
 \_\_\_\_\_ URGENT (**PLEASE CALL**)  
 \_\_\_\_\_ WITHIN 2-3 DAYS  
 \_\_\_\_\_ WITHIN 1 WEEK  
 \_\_\_\_\_ WITHIN <3 WEEKS (**PREFERRED**)

After completing this form please fax to **(401) 444-5732**. We will finalize and confirm the appointment Date and Time with your patient after receiving this referral sheet.

ORDERING PHYSICIAN (PRINT): \_\_\_\_\_  
 INDICATION FOR SCAN (PLS INCLUDE ICD-9): \_\_\_\_\_  
 PERSON COMPLETING THIS REQUEST (PRINT): \_\_\_\_\_  
 PHONE/PAGER: \_\_\_\_\_      BACK LINE #: \_\_\_\_\_  
 OFFICE FAX: \_\_\_\_\_

**EXAMINATION(S) DESIRED: (CHECK ALL THAT APPLY)**

**MRI OF HEART:**  
 \_\_\_ Function and Viability  
 \_\_\_ Congenital Heart Dz (Includes MRA)  
 \_\_\_ Assessment of Anomalous Coronary Artery  
 \_\_\_ Assessment of Bypass Grafts (Includes MRA)  
 \_\_\_ Pulmonary Vein Mapping (Includes MRA)  
 \_\_\_ r/o ARVD (Includes Function and Viability)  
 \_\_\_ Evaluation of Cardiac/Pericardial mass  
 \_\_\_ Evaluate for Pericardial Disease (Includes Function)

**MR OF VASCULAR SYSTEM (BELOW NECK):**  
 \_\_\_ MRA of Thoracic Aorta  
 \_\_\_ MRA of Thoracic Aorta w/ Aortic Valve  
 \_\_\_ MRA of Abdominal Aorta/Iliacs  
 \_\_\_ MRA of Renal Arteries  
 \_\_\_ MRA of Abdo Aorta/Lower Extremity (Runoff)

**OTHER (SPECIFY):** \_\_\_\_\_  
 \_\_\_\_\_

**CONTRAINDICATION SCREENING**

**ABSOLUTE:**

- CARDIAC PACEMAKER/ DEFIBRILLATOR/ COCHLEAR IMPLANT
- CEREBRAL ANEURYSM CLIPS (SOME ARE OK)

**RELATIVE (MUST REVIEW WITH PATIENT):**

- KNOWN OR POSSIBLE PREGNANCY
- OTHER IMPLANTED ELECTRODES, PUMPS, OR ELECTRONIC DEVICES
- CLAUSTROPHOBIA (CONSIDER PROVIDING MEDICATION)
- EXPOSURE AT ANY TIME TO WELDING, GRINDING, SHEET METAL MACHINES (THROUGH WORK OR HOBBY)
- OTHER KNOWN OR POSSIBLE METAL FRAGMENTS IN EYES, HEAD OR BODY
- WEIGHT 450 POUNDS OR MORE

ORBIT X-RAYS WILL BE DONE WHERE INDICATED

ADDITIONAL INFORMATION (OPTIONAL): \_\_\_\_\_