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MAGNETIC RESONANCE IMAGING REQUISITION

PATIENT INFORMATION

Patient Name:_____

DOB:__/__/__ (dd/mm/yyyy) Health Card #_____

Address:_____

City: _____ Province: _____

Postal Code:_____ Home Phone:_____

Is this WSIB? Y N Claim#

EXAM REQUESTED

Area to be Scanned: _____

Clinical History:

Priority Appt. to be given to Patient prior to discharge ☐

Previous Studies: MRI ☐ CT☐ X-ray ☐ US☐ NM ☐

PHYSICIAN INFORMATION

Ref. Physician:_____

Phone:_____ Fax:_____

Billing #_____

Physician Signature_____

THE FOLLOWING MUST BE COMPLETED BEFORE AN MRI CAN BE BOOKED

Patient Screening (complete the following with patient)
*__Absolute Contraindications__

Cardiac Pacemaker/Leads/Defibrillator* - - - - - - Y N
Cochlear Implants* - Y N
Neurostimulator *- Y N
Artificial Heart Valves - Y N
Retinal Detachment Surgery - - - - - - - - - - - - - - - - - Y N
Aneurysm Clips - Y N
Transdermal Medication Patches- - - - - - - - - - - - - Y N
Shrapnel / Bullets- Y N
Other medical implants - - - - - - - - - - - - - - - - - - - Y N
Does the patient need interpreter - - - - - - - - - - - - Y N
Contact person? _____-- - - - - - - - - Y N
If YES, please make sure they accompany patient to appointment
Is patient pregnant - Y N
Has metal ever gone into your eyes - - - - - - - - - - Y N
Have you ever worked with metal without eye protection - Y N
If YES, physician must order x-rays of orbits and submit x-ray report with requisition.

Is the patient over 60 years old - Y N
Renal Disease - Y N
Stroke - Y N
Hypertension - Y N
Myocardial Infarction - Y N
Diabetes - Y N

Patient Weight_____lbs_____kg eGFR _____ Date _____ (dd/mm/yyyy)

Patient Signature_____ Date _____ (dd/mm/yyyy)

****If patient is claustrophobic, referring physician will prescribe required medication. Patient is responsible for a ride home.****

Has the patient ever had any surgery on:
Please circle and describe.

		Initials
Head		
Spine		
Chest		
Abdomen		
Extremities		
Other		

RADIOLOGIST USE ONLY

Radiologist Protocol
☐ 1 (immediate)
☐ 2 (48 hours)
☐ 3 (10 days)
☐ 4 (less than 4 weeks)
☐ 5 (specif date priority)
(Staging/Dx) _____ (Breast) _____ (Other))_____

Comments:

Previous images/report:
☐ eGFR ☐ Monitor ☐ Gad **Initials**_____