MRI REQUEST

Tel: 416-586-˙4- (%
Fax: 416-586-4797

Tel: 416-946-2026
Fax: 416-946-2296

Tel: 416-323-7515
Fax: 416-323-6316

Date:______________ DD/MM/YYYY

For MRI Use Only | Booking Date: ______________ Location ______________

Patient Information

Medical Record No.: ____________________ Health Card No.:____________________ Version Code: __________

Name:________________ ____________________ DOB: ______/ ______/ ______ Sex: ☐ M ☐ F
First Name *Last Name* *day* *month* *year*

Address: ______________________________ City: ______________ Prov.: ______ Postal Code:__________

Home Tel.: ____________________ Cell: ____________________ Business Tel.: ______________

Mobility Status: ☐ Walking ☐ Wheelchair ☐ Stretcher ☐ Ambulance

Additional Info.: ______________________________

Billing Information: ☐ OHIP ☐ WSIB ☐ Non Resident/ Other

Claim Number/Insurance No.: ______________________________
(include attachments if necessary)

To be completed by Patient

FOR PATIENT SAFETY THESE QUESTIONS MUST BE ANSWERED:

YES	NO	
☐	☐	Have you had a previous MRI?
☐	☐	Has metal ever gone into your eye?
☐	☐	Do you have any kidney disease?
☐	☐	Are you on dialysis?
☐	☐	Could you be pregnant?

Date of last Menstrual Period: ______________

What is your current Weight:______________
(maximum allowable weight 550lbs./250kg, but dependent on girth)

What is your current Height:______________

Do you have any of the following?
(check all that apply)

- ☐ Aneurysm Clips
- ☐ Artificial Cardiac Valve
- ☐ Cardiac Pacemaker
- ☐ Cochlear Implants
- ☐ Coils/Stents
- ☐ Neurostimulator
- ☐ Retained Pacing Wires
- ☐ Shrapnel / Bullets

Other Implanted Devices: __________
(add additional pages if necessary)

Have you ever had surgery on your?
(check all that apply)

- ☐ Abdomen/ Pelvis
- ☐ Arms/ Legs
- ☐ Chest
- ☐ Head
- ☐ Neck
- ☐ Spine

Name all Surgeries:
____
____
____

Approximate year of surgeries *(add additional pages if necessary)*:
____
____

Patient's Signature: **X** ______________________________

Referring Physician Information

Physician's Name: ______________________________

Address:______________________________

CPSO Number: __________ Postal Code:__________

Phone: ______________ Fax: ______________

Exam Information

Area to be Scanned ***(be specific):*** ______________________________
____

Clinical Information /Working Diagnosis:
____
____
____

Completed Tests and Associated Results

Sites: ☐ MSH ☐ PMH ☐ TGH ☐ TWH ☐ WCH ☐ Outside Hospital/Clinic *(if from outside hospital, attach outside report)*

Tests:______________________________
____

Does the patient require an interpreter? ☐ Yes ☐ No If yes, what language?______________

IMPORTANT INSTRUCTIONS for Referring Physicians

If the patient has impaired renal function, you must submit a serum creatinine done within 3 months of the MRI appointment.For many implanted devices it is absolutely critical **TO LIST THE MANUFACTURER AND MODEL NUMBER** to ensure that the patient is not harmed in the magnet. For more information, see supplementary info sheet. Submit all surgical reports available.

Physician's Signature: **X** ______________________________ Date: __________

INCOMPLETE/ILLEGIBLE REQUESTS WILL BE RETURNED/FAXED BACK WITHOUT AN APPOINTMENT
FORM MUST BE COMPLETE, INCLUDING PATIENT AND PHYSICIAN SIGNATURES

Form F-2766 (2-2020