

MRI REQUEST

Tel: 416-586-4941
Fax: 416-586-4797

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

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

Patient Information

Medical Record No.: _____ Health Card No.: _____ Version Code: _____

Name: _____ DOB: ____/____/____ Sex: M F
First Name Last Name dd mm yyyy

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?

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 Name all Surgeries: _____
 - Arms/ Legs _____
 - Chest _____
 - Head _____
 - Neck _____
 - Spine _____
- Approximate year of surgeries
(add additional pages if necessary):

Date of last Menstrual Period: _____

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

What is your current Height: _____

Patient's Signature: X _____

Referring Physician Information **Exam Information**

Physician's Name: _____

Address: _____

Postal Code: _____

Phone: _____ Fax: _____

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

For MRI Use Only | Booking Date: _____

Location