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

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?

(include reports for each implant device)

YES	NO	
❒	❒	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 and approximate year of surgery:

____
____
____
____
____
____

Patient's Signature: X ____

Referring Provider Information

Provider's Name: ____________________________________

Address: ____________________________________

_________________________ Postal Code: ______________

Phone: ____________________ Fax: ____________________

Billing No.: ________________ CPSO: __________________

Completed Tests and Associated Results

Exam Information

Area to be Scanned ***(be specific):*** ________________________

____

Clinical Information / Working Diagnosis:

____
____
____
____

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.

Provider's Signature: X ____ Date: ______________

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