

Medical Imaging

30 Bond Street, Toronto, ON M5B 1W8
 Website – <http://bit.ly/2ucQCPA>

Medical Imaging MRI Requisition Form

Tel.: 416-864-5661
 Fax: 416-864-5820

APPOINTMENT

Exam Date: _____
 Arrival Time: _____
 Exam Time: _____

MRI is located on level B2 of the Cardinal Carter Wing – Enter from Queen Street

A. PATIENT INFORMATION			
MRN	DOB: DD	MMM	YYYY
Last Name		Health Card #: _____	
First Name		VC: _____	
Street Address		<input type="checkbox"/> Self-pay <input type="checkbox"/> IFH <input type="checkbox"/> WSIB Claim #: _____	
City		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex <input type="checkbox"/> Please Specify:	
Postal Code		<input type="checkbox"/> Transgender – Female to Male	
Province		<input type="checkbox"/> Transgender – Male to Female	
Country		Patient consents to leave message <input type="checkbox"/> Y <input type="checkbox"/> N	
<input type="checkbox"/> Interpreter: Language: _____		MOBILE: _____	
<input type="checkbox"/> Restricted Mobility: _____		HOME: _____	
<input type="checkbox"/> Isolation Precaution: _____		WORK: _____	
REQUIRED PATIENT INFORMATION			
Pregnant <input type="checkbox"/> Y <input type="checkbox"/> N		Weight: _____ kg	Height: _____ cm
B. EXAM INFORMATION			
Area to be scanned:			
Clinical Information:			
List <u>all</u> previous surgeries and implants:			
C. SCREENING QUESTIONS (must be completed)			
1. Have you ever had an eye injury from a metal object or required a metal fragment to be removed by a doctor?			Y <input type="checkbox"/> N <input type="checkbox"/>
2. Are you on dialysis?			Y <input type="checkbox"/> N <input type="checkbox"/>
3. Indicate if you have the following:			
Cardiac pacemaker or implantable defibrillator (ICD)	Y <input type="checkbox"/> N <input type="checkbox"/>	Drug infusion pump (insulin, antibiotic, etc...)	Y <input type="checkbox"/> N <input type="checkbox"/>
Pacing wires (epicardial)	Y <input type="checkbox"/> N <input type="checkbox"/>	Electronic monitoring device (diabetes, etc...)	Y <input type="checkbox"/> N <input type="checkbox"/>
Neurostimulator/TENS unit	Y <input type="checkbox"/> N <input type="checkbox"/>	Breast tissue expander	Y <input type="checkbox"/> N <input type="checkbox"/>
Cochlear or other ear implant	Y <input type="checkbox"/> N <input type="checkbox"/>	Eye prosthesis or implant	Y <input type="checkbox"/> N <input type="checkbox"/>
Swan Ganz line	Y <input type="checkbox"/> N <input type="checkbox"/>	Shrapnel, bullet, foreign metal object	Y <input type="checkbox"/> N <input type="checkbox"/>
Brain aneurysm clip	Y <input type="checkbox"/> N <input type="checkbox"/>	Metal rods, pins, screws, wires	Y <input type="checkbox"/> N <input type="checkbox"/>
Intravascular stent, filter, coil	Y <input type="checkbox"/> N <input type="checkbox"/>	Other metallic implants (specify...)	Y <input type="checkbox"/> N <input type="checkbox"/>
Programmable Shunt	Y <input type="checkbox"/> N <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/>
D. ORDERING PHYSICIAN INFORMATION & SIGNATURE			
Ordering Physician Name (please print):		Copy to (please print):	
Signature:	Date:		
CPSO #:	Billing #:		
Fax:	Phone #:		