SouthlakeHealth

596 Davis Drive
Newmarket, Ontario L3Y 2P9

**Diagnostic Imaging**

Health Record #: _____ Complete or place barcoded patient label here

Patient Name: *(Print first, last)* _____

DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male

OHIP #: _____ Version Code: _____

Account #: _____ Date of Admission: dd / mm / yy

# *MRI Requisition*

***Please fax to (905) 830-5966***

| | | |
|---|---|---|
| **Patient Name:** *(print first, last)* | | **Date of Birth:** dd / mm / yy |
| **Address:** Street Number + Name Apartment | | **Patient Weight:** _____ **kg** |
| City Province Postal Code | | **Cell:** ( ) |
| **Health Card Number:** | **Version Code:** | **Home:** ( ) |
| **Other Insurance:** | **Email:** | |

**Patient DOES NOT consent to be contacted via:** ☐ Text ☐ Email (for patient privacy information see the next page)

**Patient not available:** From: dd / mm / yy To: dd / mm / yy Reason: _____

**Hoyer Lift Required?** ☐ Yes ☐ No **Patient arriving by Ambulance Transfer?** ☐ Yes ☐ No

**PAEDIATRIC USE ONLY**: Is general anaesthesia required? ☐ Yes ☐ No

**Clinical History and Diagnostic Question:** ☐ Cancer diagnosis or staging?

Previous tests or surgery date/where?

**EXAM REQUIRED** *(check all that apply)*

**Brain**
- ☐ Routine
- ☐ MS/demyelination
- ☐ Seizure
- ☐ Trauma/pediatric
- ☐ Brain and MRA COW
- ☐ CN8 (IAC)
- ☐ Brain and MRV
- ☐ Orbits
- ☐ Sella/pituitary
- ☐ Fast CVA/TIA brain

**Head and Neck**
- Brachial Plexus ☐ Rt ☐ Lt
- ☐ Neck (soft tissue)
- ☐ Parathyroids
- ☐ TMJs
- ☐ Parotids

**Thorax and Breast**
- Breast: ☐ Mass/Follow-up ☐ Implant
- ☐ Mediastinal Mass

**Abdomen**
- ☐ Liver/Spleen
- ☐ MRCP Only
- ☐ Pancreas (includes MRCP)
- ☐ Enterography
- ☐ Adrenals
- ☐ Kidneys
- ☐ PCKD (renal size only)

**Spine**
- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar
- ☐ Sacrum/Coccyx
- ☐ Lumbosacral Plexus
- ☐ Sacroiliac Joints
- Whole Spine
  - ☐ Cord Compression
  - ☐ Metastases

**Angiogram (with Gadolinium)**
- ☐ Subclavians (bilateral)
- ☐ Renal/Mesenteric
- ☐ Thoracic Outlet
- ☐ Peripheral Runoff
- Aorta: ☐ Thoracic ☐ Abdominal
- Carotids/ vertebrals: ☐ Routine ☐ Dissection

**Pelvis**
- ☐ Pelvis (Routine)
- ☐ Rectal Mass
- ☐ Anal Fistula
- ☐ Testicular Mass
- ☐ Urethra (female or posterior male)
- ☐ Prostate

**Musculoskeletal (Upper Extremity)**

| | | |
|---|---|---|
| Shoulder | ☐ R | ☐ L |
| Elbow | ☐ R | ☐ L |
| Hand/Wrist (inflam, arthritis) | ☐ R | ☐ L |

Wrist/Thumb/Finger - Specify:
Palpable Lump Workup – Specify:

**Musculoskeletal (Lower Extremity)**

| | | |
|---|---|---|
| Hip | ☐ Rt | ☐ Lt |
| Pelvis (bony) | ☐ Rt | ☐ Lt |
| Hamstring (proximal) | ☐ Rt | ☐ Lt |
| Knee | ☐ Rt | ☐ Lt |
| Ankle/Hindfoot | ☐ Rt | ☐ Lt |
| Achilles Only | ☐ Rt | ☐ Lt |
| Forefoot (Osteomyelitis) | ☐ Rt | ☐ Lt |
| Hindfoot (Osteomyelitis) | ☐ Rt | ☐ Lt |
| Forefoot (Arthritis) | ☐ Rt | ☐ Lt |
| Hindfoot (Arthritis) | ☐ Rt | ☐ Lt |
| Forefoot/Midfoot (routine/mass) | ☐ Rt | ☐ Lt |

Palpable Lump Workup – Specify:

**Palpable Lump Work Up**
Body/Other – Specify:

☐ **Cardiac**

**Other Request** *(not listed above)*
Specify:

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# *MRI Requisition*

***Please fax to (905) 830-5966***

**Renal Function Assessment** *(please check appropriate):*

☐ History of Renal Disease:

Creatinine= obtained on ____ / ____ / ____ eGFR= _____.

☐ On Dialysis

☐ Acute Kidney Injury (AKI): for IN-patient/ED patients only

☐ The patient has **NONE** of the above risk factors

Venous Access in situ: ☐ Port ☐ PICC

| **MRI SAFTEY ASSESSMENT** – does the patient have any of the following: | | Comments: |
|---|---|---|
| *Pacemaker (implant information required | ☐ Yes ☐ No | |
| *Cerebral Aneurysm Clips (implant information required) | ☐ Yes ☐ No | |
| *Cochlear Implant (send to implanting hospital) | ☐ Yes ☐ No | |
| Neurostimulator device | ☐ Yes ☐ No | |
| Insulin/chemotherapy pump | ☐ Yes ☐ No | |
| Vascular stent (indicate location) | ☐ Yes ☐ No | |
| Metal rods, plates, screws, nails | ☐ Yes ☐ No | |
| Ocular implant (cataract lens implant safe) | ☐ Yes ☐ No | |
| Penile implant | ☐ Yes ☐ No | |
| Transdermal Patches | ☐ Yes ☐ No | |
| Ever had metal fragments in eyes? | ☐ Yes ☐ No | |
| Do they work with metal (i.e. grinder or welder) (see note below) | ☐ Yes ☐ No | |
| Any other metallic, magnetic or electronic implants? | ☐ Yes ☐ No | |
| Is the patient pregnant? | ☐ Yes ☐ No | |
| Does the patient have claustrophobia (see note below) | ☐ Yes ☐ No | |
| Allergy to MRI contrast? | ☐ Yes ☐ No | |
| Does the patient have a glucose monitor sensor? (pt must remove before test) | ☐ Yes ☐ No | |

**Note**: If sedation is required for claustrophobia, please arrange this with your patient. MRI Department will not dispense sedation. If there is a possibility or history of metal being in your patient's eyes, please arrange for orbit x-rays to confirm or exclude any possible metal in the eyes. Have the x-ray report sent with this requisition. This will help ensure that the patient's MR experience goes smoothly.

Referring Physician: *(print first, last):* _____ Signature _____ Date dd / mm / yy

**PRIVACY POLICY DOCUMENTATION**
via QR code link below or via Southlake's privacy office webpage

SMRI



SL0274B_01 (11/24) "Diagnostic Imaging" Review (11/27)