SouthlakeHealth

596 Davis Drive
Newmarket, Ontario L3Y 2P9

Diagnostic Imaging

Referring Physician: *(print first, last):* _____

CPSO# _____ Signature: _____

Address: _____

Office Phone: _____ Office Fax: _____

Date: 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:

SMRI

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

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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.

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

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