

MRI Requisition

Please DO NOT cover Referring Physician information

Referring Physician: (print first, last): _____
 CPSO# _____ Signature: _____
 Address: _____
 Office Phone: _____ Office Fax: _____
 Date: dd / mm / yy

Please fax to (905) 830-5966

Patient Name: (print first, last) _____		Date of Birth: <u>dd</u> / <u>mm</u> / <u>yy</u>
Address:	Street Number + Name _____	Apartment _____
City _____	Province _____	Postal Code _____
Health Card Number: _____	Version Code: _____	Patient Weight: _____ kg
Other Insurance: _____	Email: _____	Cell: () _____
Patient DOES NOT consent to be contacted via: <input type="checkbox"/> Text <input type="checkbox"/> Email (for patient privacy information see the next page)		
Patient not available: From: <u>dd</u> / <u>mm</u> / <u>yy</u> To: <u>dd</u> / <u>mm</u> / <u>yy</u> Reason: _____		
Hoyer Lift Required? <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient arriving by Ambulance Transfer? <input type="checkbox"/> Yes <input type="checkbox"/> No
PAEDIATRIC USE ONLY: Is general anaesthesia required? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Clinical History and Diagnostic Question: _____		<input type="checkbox"/> Cancer diagnosis or staging?
Previous tests or surgery date/where? _____		
EXAM REQUIRED (check all that apply)		
Brain <input type="checkbox"/> Routine <input type="checkbox"/> MS/demyelination <input type="checkbox"/> Seizure <input type="checkbox"/> Trauma/pediatric <input type="checkbox"/> Brain and MRA COW <input type="checkbox"/> CN8 (IAC) <input type="checkbox"/> Brain and MRV <input type="checkbox"/> Orbits <input type="checkbox"/> Sella/pituitary <input type="checkbox"/> Fast CVA/TIA brain	Spine <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacrum/Coccyx <input type="checkbox"/> Lumbosacral Plexus <input type="checkbox"/> Sacroiliac Joints Whole Spine <input type="checkbox"/> Cord Compression <input type="checkbox"/> Metastases	Musculoskeletal (Upper Extremity) Shoulder <input type="checkbox"/> R <input type="checkbox"/> L Elbow <input type="checkbox"/> R <input type="checkbox"/> L Hand/Wrist (inflam, arthritis) <input type="checkbox"/> R <input type="checkbox"/> L Wrist/Thumb/Finger - Specify: Palpable Lump Workup – Specify:
Head and Neck Brachial Plexus <input type="checkbox"/> Rt <input type="checkbox"/> Lt <input type="checkbox"/> Neck (soft tissue) <input type="checkbox"/> Parathyroids <input type="checkbox"/> TMJs <input type="checkbox"/> Parotids	Angiogram (with Gadolinium) <input type="checkbox"/> Subclavians (bilateral) <input type="checkbox"/> Renal/Mesenteric <input type="checkbox"/> Thoracic Outlet <input type="checkbox"/> Peripheral Runoff Aorta: <input type="checkbox"/> Thoracic <input type="checkbox"/> Abdominal Carotids/vertebrals: <input type="checkbox"/> Routine <input type="checkbox"/> Dissection	Musculoskeletal (Lower Extremity) Hip <input type="checkbox"/> Rt <input type="checkbox"/> Lt Pelvis (bony) <input type="checkbox"/> Rt <input type="checkbox"/> Lt Hamstring (proximal) <input type="checkbox"/> Rt <input type="checkbox"/> Lt Knee <input type="checkbox"/> Rt <input type="checkbox"/> Lt Ankle/Hindfoot <input type="checkbox"/> Rt <input type="checkbox"/> Lt Achilles Only <input type="checkbox"/> Rt <input type="checkbox"/> Lt Forefoot (Osteomyelitis) <input type="checkbox"/> Rt <input type="checkbox"/> Lt Hindfoot (Osteomyelitis) <input type="checkbox"/> Rt <input type="checkbox"/> Lt Forefoot (Arthritis) <input type="checkbox"/> Rt <input type="checkbox"/> Lt Hindfoot (Arthritis) <input type="checkbox"/> Rt <input type="checkbox"/> Lt Forefoot/Midfoot (routine/mass) <input type="checkbox"/> Rt <input type="checkbox"/> Lt Palpable Lump Workup – Specify:
Thorax and Breast Breast: <input type="checkbox"/> Mass/Follow-up <input type="checkbox"/> Implant <input type="checkbox"/> Mediastinal Mass	Pelvis <input type="checkbox"/> Pelvis (Routine) <input type="checkbox"/> Rectal Mass <input type="checkbox"/> Anal Fistula <input type="checkbox"/> Testicular Mass <input type="checkbox"/> Urethra (female or posterior male) <input type="checkbox"/> Prostate	Palpable Lump Workup Body/Other – Specify: <input type="checkbox"/> Cardiac
Abdomen <input type="checkbox"/> Liver/Spleen <input type="checkbox"/> MRCP Only <input type="checkbox"/> Pancreas (includes MRCP) <input type="checkbox"/> Enterography <input type="checkbox"/> Adrenals <input type="checkbox"/> Kidneys <input type="checkbox"/> PCKD (renal size only)	Other Request (not listed above) Specify: _____	



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Renal Function Assessment (please check appropriate):

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

