St. Michael's

Inspired Care. Inspiring Science.

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

PATIENT INFORMATION		
MRN	**DOB:** DD MMM YYYY	**Health Card #:** **VC:**
Last Name		
First Name		☐ **Self-pay** ☐ **IFH** ☐ **WSIB Claim #:**_____
Street Address		☐ **Female** ☐ **Male** ☐ **Intersex**
City	**Postal Code**	☐ **Transgender – Female to Male**
Province	**Country**	☐ **Transgender – Male to Female** ☐ **Please specify:**
☐ **Interpreter: Language**: _____		**Patient consents to leave message** ☐ **Y** ☐ **N**
☐ **Restricted Mobility**: _____		**MOBILE:** _____
☐ **Isolation Precaution**: _____		**HOME:** _____
		WORK: _____

REQUIRED PATIENT INFORMATION		
Pregnant ☐ Y ☐ N	Weight: _____lbs/kg	Height: _____in/cm

EXAM INFORMATION
Area to be scanned:
Clinical Information:
List <u>all</u> previous surgeries and implants:

SCREENING QUESTIONS (must be completed)			
1. Have you ever had an eye injury from a metal object that required a metal fragment to be removed by a doctor?			Y ☐ N ☐
2. Do you have kidney disease (kidney transplant, single kidney, kidney surgery, kidney cancer) or are on dialysis?			Y ☐ N ☐
3. Indicate if you have the following:			
Cardiac pacemaker or implantable defibrillator (ICD)	Y ☐ N ☐	Breast tissue expander	Y ☐ N ☐
Pacing wires (epicardial)	Y ☐ N ☐	Eye prosthesis or implant	Y ☐ N ☐
Neurostimulator/TENS unit	Y ☐ N ☐	Shrapnel, bullet, foreign metal object	Y ☐ N ☐
Cochlear or other ear implant	Y ☐ N ☐	Metal rods, pins, screws, wires	Y ☐ N ☐
Swan Ganz line	Y ☐ N ☐	Hearing aid(s)	Y ☐ N ☐
Brain aneurysm clip	Y ☐ N ☐	Dentures, partial plate	Y ☐ N ☐
Intravascular stent, filter, coil	Y ☐ N ☐	Tattoos, permanent make-up	Y ☐ N ☐
Programmable Shunt	Y ☐ N ☐	Body piercing(s)	Y ☐ N ☐
Drug infusion pump (insulin, etc…)	Y ☐ N ☐	Medication patch(es)	Y ☐ N ☐
Electronic monitoring device (diabetes, etc…)	Y ☐ N ☐	Other metallic implants (specify…)	Y ☐ N ☐

ORDERING PHYSICIAN INFORMATION & SIGNATURE		
Ordering Physician Name (please print)		Copy to (please print):
Signature:	Date:	
CPSO #:	Billing #:	
Fax:	Phone #:	