SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, Ontario L3Y 2P9

Diagnostic Imaging - FAX: 905-830-5966

Health Record #: _____ Complete or place barcoded patient label here
Patient Name: *(Print first, last)* _____
DOB: mm / dd / yy Age: _____ ❑ Female ❑ Male
OHIP #: _____ Version Code: _____
Phone #: _____

MRI Requisition

❑ OUT-PATIENT ❑ IN-PATIENT

Patient Name: *(print first, last)*

Address: Street Number + Name Apartment

City Province Postal Code

Health Card Number: **Version Code:**

Other Insurance: **WSIB Number:**

Home: ( ) **Work/Other:** ( )

Patient not available: From: mm / dd / yy To: mm / dd / yy

Reason:

Area to be scanned:

Diagnostic Question:

Clinical History:

Previous tests/dates/where?

Previous Surgery: When?

MRI SAFETY ASSESSMENT Does the patient have any of the following:			**Comments:**
* Pacemaker *(absolute contraindication)*	❑ Yes	❑ No	
* Cerebral aneurysm clips *(absolute contraindication)*	❑ Yes	❑ No	
* Cochlear implants *(absolute contraindication)*	❑ 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)	❑ Yes	❑ No	
Any other metallic, magnetic or electronic implants?	❑ Yes	❑ No	
Is the patient pregnant?	❑ Yes	❑ No	
Does the patient have claustrophobia?	❑ Yes	❑ No	
Allergy to MRI contrast?	❑ Yes	❑ No	

Appointment Date: mm / dd / yy

Appointment Time:

Arrival Time:

Hospital Record #:

Date of Birth: mm / dd / yy

Patient Weight: _____ **kg**

FOR PAEDIATRIC USE ONLY:
Is general anesthesia required? ❑ Yes ❑ No

RENAL FUNCTION ASSESSMENT
(please check (✓) appropriate)

❑ Hx of Renal Disease ❑ Stroke
❑ On Dialysis ❑ Hypertension
❑ Diabetes ❑ Over 70 yrs of age
❑ Chemotherapy ❑ Gout
❑ Vascular Disease ❑ Cirrhosis

If **YES** to any of the above we require a current creatinine/eGFR (in the last 6 months) attached to the requisition.

❑ The patient has **NONE** of the above risk factors.

Venous Access in situ: ❑ Port ❑ PICC

RADIOLOGIST USE ONLY:

Priority: *(please circle)* (1) (2) (3) (4)

Is this a specified date (timed) procedure?

If yes, specify date: _____

Clinical Indications for Scan:
❑ Cancer Staging and/or Diagnosis
❑ Breast Cancer Screening
❑ Other Diagnosis

❑ Head
❑ Neck
❑ Spine - level
❑ Abdomen/Pelvis - area
❑ Extremity - area
❑ Chest/Cardiac
❑ Breast
❑ Runoff
❑ Contrast

Radiologist/MRT (MR): *(print first, last)*

Radiologist/MRT (MR) signature:

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

Signature: **Office Phone:** ( )

Address: **Fax Number:** ( )

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.

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