www. MRIappointments.com
email: jmf@MRIappointments.com

Tel: 1 866 899 4674
Fax: 1 866 307 1247

MRI REQUISTION FORM (Ontario: for non-OHIP testing including Insurance and Med Legal . Use also with DTI and MRI/SPECT requests)

Patient Name:(last)_____(first)_____
Address:_____
_____
City:_____ Postal Code:_____
Phone (C) (___) _____ (H) (___) _____ (W) (___) _____
Date of Birth (mm/dd/yy): _____Weight:____ ☐ Kg ☐ Lbs Height_____
☐ WSIB Claim #_____ ☐ Blue Cross: _____
☐ Self Pay (patients willing to go to U.S. or for non-res. only)
☐ Disability or Motor Vehicle Claim. Claim Number_____
☐ Male ☐ Female

Desired location of test:
☐ Ontario ☐ B.C.
☐ Quebec ☐ Alberta
☐ Nova Scotia ☐ Saskatchewan
☐ New Brunswick
☐ Require Stand-Up Open MRI in B.C.
☐ U.S. Michigan (Cass City)
☐ North Dakota (Pembina)
Notes:
_____

SCAN REQUIRED (specify body part(s)):
_____
SPECIALTY SCANS: ☐ DTI of the Head/Brain ☐ MRI / Nuc Med SPECT of Head/ Brain
☐ Flexion –Extension Spine Views (Stand-Up Open MRI in B.C.)
DIAGNOSTIC QUESTION:
_____
_____
_____
CLINICAL INFORMATION:
_____
_____

OTHER TESTS and RESULTS to DATE
Please forward any relevant reports, X-Ray Films, CT Scans or Ultrasounds
☐ MRI _____
☐ X-Ray _____
☐ CT _____
☐ US _____
☐ Myelogram _____
☐ Angiogram _____
☐ Nuc. Med. _____
☐ Arthroscopy _____
(date and location of test)

DOES the PATIENT have any of the following:	YES	NO		YES	NO
Cardiac Pacemaker	☐	☐	Dental appliances …dentures, retainer, braces	☐	☐
Artificial cardiac valve Model#_____ Type _____ Year _____	☐	☐	Metal rods, Plates, Nails, Screws	☐	☐
Aneurysm Clip	☐	☐	Embedded shrapnel or bullets	☐	☐
Neurostimulator	☐	☐	Prosthetic device…limb, eye, joint, ear	☐	☐
Cochlear Implant	☐	☐	Is the patient subject to claustrophobia?	☐	☐
Insulin / Chemotherapy Pump	☐	☐	If yes, family physician to prescribe medication		
Coronary Bypass Graft / Vascular Stent	☐	☐	Body piercing	☐	☐
Porta Cath	☐	☐	Tattoos	☐	☐
Ocular Implants	☐	☐	Is there a chance the patient is pregnant?	☐	☐
Transdermal patches	☐	☐	Previous Surgery? If YES please describe:		
Has patient worked with metal – grinding, welding?	☐	☐			
Has patient ever had metal fragments in eyes?	☐	☐			
Has patient been exposed to metallic dust?	☐	☐			

Medical History Assessment
☐ History of Renal Disease ☐ Stroke ☐ On Dialysis ☐ Diabetes ☐ > 70 years of Age ☐ Chemotherapy ☐ Vascular Disease
If YES to any of the above include current Creatinine and eGFR (last 3 mo.) with requisitions. ☐ Patient has none of these

Referring Physician:_____
Registration ID#_____
Address: _____
Tel: (____) _____ Fax: (___) _____

Copies to be Sent to:_____
Address:_____
_____
Tel: (___) _____ Fax: (____) _____

Physician's Signature:_____

If sedation is required for claustrophobia, please arrange with patient. MRI department does not provide medications.
If there is a possibility or history of metal in patient's eyes, please arrange for orbit x-rays to confirm or exclude possibility of metallic foreign body in orbit.
Please include orbit report with this requisition. Fax to 1 866 899 4674