

## MRI Requisition

### Diffusion Tensor Imaging and Functional MRI Testing

*(For use with Disability Insurance or Medical-Legal Situations only)*

Patient Last Name: _____		First: _____	
Pronoun: <input type="checkbox"/> He/Him <input type="checkbox"/> She/Her <input type="checkbox"/> They/Them			
Address: _____			
City: _____		Prov: _____	Postal Code: _____
Date of Birth (mmm/dd/yy): _____		Phone (H): _____	(C): _____
E-Mail: _____		Height _____	Weight: _____ <input type="checkbox"/> Kg <input type="checkbox"/> Lbs
WSIB / Insurance Claim #: _____		Date of Loss: _____	

Exam: <input type="checkbox"/> Head/Brain	<b>Relevant Tests to Date</b>
	Please forward any relevant reports, <input type="checkbox"/> MRI _____ <input type="checkbox"/> CT _____
CLINICAL INFORMATION/ RELEVANT HISTORY(required)	<input type="checkbox"/> SPECT _____
	<input type="checkbox"/> Xray _____
	<input type="checkbox"/> Other : _____
<i>(date and location of test if known)</i>	

MRI Safety Questions					
	Yes	No		Yes	No
Has patient had a previous MRI?	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pacemaker/ Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Metallic foreign body in the eye.	<input type="checkbox"/>	<input type="checkbox"/>	Brain Aneurysm clip.	<input type="checkbox"/>	<input type="checkbox"/>
If yes, was it removed?	<input type="checkbox"/>	<input type="checkbox"/>	Spine neurostimulator	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant or breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	Body jewelry, piercings, tattoos?	<input type="checkbox"/>	<input type="checkbox"/>
Claustrophobic?	<input type="checkbox"/>	<input type="checkbox"/>	Ear implants (excluding hearing aids)	<input type="checkbox"/>	<input type="checkbox"/>
Drug allergies	<input type="checkbox"/>	<input type="checkbox"/>	Implanted devise or surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Mobility aids required (example: wheel chair, stretcher etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please provide details (procedure type, make/model, date)		
Transdermal patches	<input type="checkbox"/>	<input type="checkbox"/>			

Referring Physician (First Last): _____		CPSO: _____	
Address: _____		City: _____	Prov: _____ Post: _____
Tel: _____		Fax: _____ Signature: _____	
Copies to:			
Physician (First Last): _____		Ph: _____ Fax: _____	

Radiologist Use Only: Comments/Protocol