ST. MICHAEL'S
UNITY HEALTH TORONTO

Medical Imaging
30 Bond Street, Toronto, ON M5B 1W8
Website – http://bit.ly/2ucQCPA

Tel.: 416-864-5661
Fax: 416-864-5820

Medical Imaging
MRI Requisition Form

APPOINTMENT
Exam Date: _____
Arrival Time: _____
Exam Time: _____

MRI is located on level B2 of the Cardinal Carter Wing – Enter from Queen Street

A. PATIENT INFORMATION

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

REQUIRED PATIENT INFORMATION

Pregnant ☐ Y ☐ N	Weight: _____kg	Height: _____cm

B. EXAM INFORMATION

Area to be scanned:

Clinical Information:

List all previous surgeries and implants:

C. SCREENING QUESTIONS (must be completed)

1. Have you ever had an eye injury from a metal object or required a metal fragment to be removed by a doctor?	Y ☐ N ☐
2. Are you on dialysis?	Y ☐ N ☐

3. Indicate if you have the following:

Cardiac pacemaker or implantable defibrillator (ICD)	Y ☐ N ☐	Drug infusion pump (insulin, antibiotic, etc…)	Y ☐ N ☐
Pacing wires (epicardial)	Y ☐ N ☐	Electronic monitoring device (diabetes, etc…)	Y ☐ N ☐
Neurostimulator/TENS unit	Y ☐ N ☐	Breast tissue expander	Y ☐ N ☐
Cochlear or other ear implant	Y ☐ N ☐	Eye prosthesis or implant	Y ☐ N ☐
Swan Ganz line	Y ☐ N ☐	Shrapnel, bullet, foreign metal object	Y ☐ N ☐
Brain aneurysm clip	Y ☐ N ☐	Metal rods, pins, screws, wires	Y ☐ N ☐
Intravascular stent, filter, coil	Y ☐ N ☐	Other metallic implants (specify…)	Y ☐ N ☐
Programmable Shunt	Y ☐ N ☐		Y ☐ N ☐

D. ORDERING PHYSICIAN INFORMATION & SIGNATURE

Ordering Physician Name (please print):		Copy to (please print):
Signature:	Date:	
CPSO #:	Billing #:	
Fax:	Phone #:	