ST. JOSEPH'S
UNITY HEALTH TORONTO

MAGNETIC RESONANCE IMAGING (MRI)
OUTPATIENT REQUISITION

St. Joseph's Health Centre
Diagnostic Imaging Department
30 The Queensway, Toronto ON

Bookings Only: 416-530-6169
General Calls: 416-530-6001
Fax Line: 416-530-2091

Name:
Male ☐ Female ☐
MRN :
DOB:
Address:

Telephone:
OHIP #:

INCOMPLETE FORMS WILL BE RETURNED AND NOT BE PROCESSED

Area to be Scanned (be specific):

STUDY PRIORITY: ☐ **STAT/TODAY (Call MRI Radiologist)** ☐ **URGENT** ☐ **ROUTINE** **WSIB/Third Party Claim Number:**

CURRENT PATIENT LOCATION: ☐ **EMERGENCY** ☐ **Inpatient** ☐ **Clinic/ACC** ☐ **Outpatient**

CLINICAL HISTORY **Isolation Precautions:** ☐ **N/A** ☐ **Contact** ☐ **Droplet** ☐ **Airborne** ☐ **Reverse**

MANDATORY INFORMATION (MUST BE COMPLETED PRIOR TO SUBMISSION)

Is the patient on Dialysis? ☐ YES ☐ NO

Previous allergic reaction to a MR contrast agent ☐ YES ☐ NO

Operative report required for all surgeries listed below:

Head: Brain ☐ YES ☐ NO
Eye ☐ YES ☐ NO
Ear ☐ YES ☐ NO
Chest/Heart ☐ YES ☐ NO

Type and date of other surgeries. ***Operative report required for all implants including model make and number for MR Safety reasons.

Does the patient consent to appointment information being disclosed in a telephone message? ☐ YES ☐ NO

Is patient able to come on short notice? ☐ YES ☐ NO

Lift Device Required? ☐ YES ☐ NO

Sign Language Interpreter Required? ☐ YES ☐ NO

Other Language Interpreter Required?

Referring Physician: If patient requires X-ray to rule out metallic foreign bodies, do you give permission for the X-rays? ☐ YES ☐ NO

PATIENT SCREENING

Cardiac Pacemaker or pacing wires ☐ YES ☐ NO

*** *If yes to above, then contraindication to MR exam* ***

Aneurysm Clip ☐ YES ☐ NO
Heart Valve Replacement ☐ YES ☐ NO
Neuro-stimulator or residual wires ☐ YES ☐ NO
Cochlear Implant ☐ YES ☐ NO
Intrauterine Device ☐ YES ☐ NO
Hearing Aid ☐ YES ☐ NO
Medication Patches ☐ YES ☐ NO
Shrapnel or Bullets ☐ YES ☐ NO
Surgical Rods or Staples ☐ YES ☐ NO
Prosthesis (limb, joint,eye, ear) ☐ YES ☐ NO
Body Piercing/Jewellery ☐ YES ☐ NO
Other Implanted Devices: ☐ YES ☐ NO
Model make and number_____

Have you EVER cut, welded or ground metal? ☐ YES ☐ NO

Have you EVER had metal in your eye? ☐ YES ☐ NO

Since your last MR exam? ☐ YES ☐ NO

Is there a chance that you might be pregnant? ☐ YES ☐ NO

If yes, do you consent to an MRI while pregnant? ☐ YES ☐ NO

Are you claustrophobic? ☐ YES ☐ NO

Height: **Weight:**

Patient Signature:

REQUESTING PHYSICIAN

Physician Name:
Physician Specialty:
Address:

Telephone Number:
Pager Number:
Fax:
Copies to:

DATE/TIME	**Physician Signature**	**Physician's Name (Please Print)**
DD / Month / YYYY ____:__ h		