Orillia Soldiers' Memorial Hospital
170 Colborne St. West, Orillia, ON L3V 2Z3 Tel: **705-327-9127** Fax: **705-330-3224**

Request for Magnetic Resonance Imaging (MRI) Examination

(By Appointment Only)

PATIENT INFORMATION	MRN No.	**APPOINTMENT DATE:**	**TIME:**
☐ IN-PATIENT ☐ OUT-PATIENT ☐ ER			**ARRIVAL TIME:**

Last Name		**First Name**		
Date of Birth (d/m/y)	☐ M ☐ F	**Health Card No.**	**WSIB No.**	**3rd Party Ins. No.**

Address

City	**Postal Code**	**Contact Number**	☐ **OK to leave voice mail message**

PROCEDURE REQUESTED:

For MSK requests, please order general x-ray images of the affected joint if recent imaging has not been completed at OSMH.

RELEVANT CLINICAL HISTORY:

MRI Safety Assessment *Does the patient have any of the following:*

Previous Surgeries:	When:

Pacemaker *(absolute contraindication)*	☐ YES	☐ NO
Cerebral aneurysm clips *(absolute contraindication)*	☐ YES	☐ NO
Cochlear implants *(absolute contraindication)*	☐ YES	☐ NO
Brain Operation	☐ YES	☐ NO
Heart Operation	☐ YES	☐ NO
Prosthetic heart valve	☐ YES	☐ NO
Neurostimulator device	☐ YES	☐ NO
Insulin/chemotherapy pump	☐ YES	☐ NO
Coronary bypass graft / vascular stent	☐ YES	☐ NO
Metal rods, plates, screws, nails	☐ YES	☐ NO
Any other metallic, magnetic or electronic implants?	☐ YES	☐ NO
Retained pacing wires	☐ YES	☐ NO
Shrapnel/ bullets	☐ YES	☐ NO
Ocular implant (cataract lens implant safe)	☐ YES	☐ NO
Penile implant	☐ YES	☐ NO
Tissue Expander	☐ YES	☐ NO
Transdermal patches	☐ YES	☐ NO
Hearing Aids	☐ YES	☐ NO
Dentures	☐ YES	☐ NO
Ever had metal fragments in eyes?	☐ YES	☐ NO
If YES, send recent X-ray Orbit Report		
Is the patient pregnant?	☐ YES	☐ NO
Is the patient claustrophobic?	☐ YES	☐ NO
(If Yes, physician to prescribe sedation)		
Allergic to MRI contrast?	☐ YES	☐ NO
Does the patient have mobility issues?	☐ YES	☐ NO

PATIENT WEIGHT: ☐ lbs ☐ kg PATIENT HEIGHT:

For Paediatric Use Only:
Is general anesthesia required? ☐ YES ☐ NO

Renal Function Assessment (please check appropriate box)

☐ Hx of Renal Disease ☐ Chemotherapy ☐ Hypertension
☐ Vascular Disease ☐ Over 70 years ☐ Stroke
☐ Cirrhosis ☐ On Dialysis ☐ Gout ☐ Diabetes
☐ Patient has NONE of the risk factors

If YES to any of the above, we require a current creatinine/eGFR in the last 6 months.
CREATININE LEVEL: CR _____ **eGFR** _____ **DATE:** _____

FOR DEPARTMENT USE ONLY PRIORITY: ☐ P1 ☐ P2 ☐ P3 ☐ P4

Signature:

☐ HEAD	☐ PELVIS	☐ ARTHROGRAM
☐ SPINE	☐ UPPER EXTREMITY	☐ CONTRAST
☐ NECK	☐ LOWER EXTREMITY	☐ FBO X-ray
☐ ABDOMEN	☐ CHEST	

Specify series required:

☐ ** NPO Midnight **

☐ ** NPO + Fleet Enema 6 hours prior to exam **

20	30	40	50	60

PHYSICIAN INFORMATION

Physician's Name (Please PRINT clearly)

Address/ Phone

CPSO#

OFFICE STAMP:

Physician's Signature X

INCOMPLETE, ILLEGIBLE AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED.