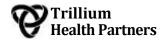
## INCOMPLETE AND/ OR UNSIGNED REQUISITIONS WILL BE RETURNED



## DIAGNOSTIC IMAGING REQUISITION M.R.I.

## IF UNABLE TO KEEP APPOINTMENT, PLEASECALL (905)848-7554 24HOURS IN ADVANCETO CANCEL

Booking Office: Telephone (905) 848-7554	Is this a WSIB Claim?	Yes	No
Fax (905) 848-7295	Claim#		

Technologist's Comments:	Diagnostic Imaging Protocol Use Only		
Patient Name:	PATIENT SCREENING		
<b></b>	For all questions, please check either 'Yes' or 'No'  YES NO		
Date of Birth: Male Female	Note: If the answer to #1 or #2 is 'Yes', an X-Ray of the Orbits must be carried out and the report is attached		
Health Card # Version Code	must be curried out and the report to attached		
Address:	Have you ever worked as a metal grinder/Welder?		
	2 Has metal ever gone into your eye?		
,	3 Could you be pregnant?		
Telephone Res: Bus:	4. Do conclusion and the fellowing?		
Exam Requested:	4 Do you have any of the following?  Cardiac Pacemaker		
Areas of Interest:	-Artificial Cardiac Valve Make & Model		
	- Aneurysm Clips Type/Where? - Neurostimulator		
	- Cochlear Implants		
Clinical Information:	- Lens Implants If 'Yes", when?		
	- Shrapnel / Bullet If 'Yes', where?		
	- Porta-Cath Pump?		
	- Dentures/ Braces		
	-Any other implanted device Specify		
Accurate Weight (Max 300lb):	5. Have you ever had surgery on your		
Height:	- Head, Neck		
Is Patient on Dialysis? Yes No	- Spine		
☐ Ambulatory	- Chest		
☐ Ambulatory with assistance	-Abdomen		
□ Non-Ambulatory	-Arms/ Legs		
* Please attach relevant previous reports	If the answer to any of the above is 'Yes", please explain:		
· · · · · · · · · · · · · · · · · · ·	1		
Referring Physician:			
Address:	6. Is the patient subject to claustrophobia?		
Phone: OHIP Billing Number:	If 'Yes', medication is to be prescribed.		
Fax:			
Physician Signature:	Patient Signature:		
Redirect to CVH HHS (Oakville)	Tech Signature:		
or Any if waitlist is shorter	Tech Verified Side: Please initial		