SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, Ontario L3Y 2P9

Diagnostic Imaging - FAX: 905-830-5966

Health Record #: ____________ Complete or place barcoded patient label here
Patient Name: (Print first, last) ____________
DOB: dd / mm / yy Age: ______ ❑ Female ❑ Male
OHIP #: ____________ Version Code: ____________
Phone #: ____________

MRI Requisition

❑ OUT-PATIENT ❑ IN-PATIENT ❑ ED PATIENT ❑ WSIB ❑ INSURANCE Reference #: ____________

Patient Name: *(print first, last)*	**Appointment Date:** dd / mm / yy
Address: Street Number + Name, Apartment	**Appointment Time:**
City, Province, Postal Code	**Arrival Time:**
Health Card Number: **Version Code:**	**Hospital Record #:**
Other Insurance:	**Date of Birth:** dd / mm / yy
Home: ( ) **Work/Other:** ( )	**Patient Weight:** ________ kg
Patient not available: From: dd / mm / yy To: dd / mm / yy **Reason:**	**FOR PAEDIATRIC USE ONLY:** Is general anaesthesia required? ❑ Yes ❑ No
Area to be scanned: **Diagnostic Question:** **Clinical History:**	**RENAL FUNCTION ASSESSMENT** *(please check (✔) appropriate)* ❑ Hx of Renal Disease: **Creatinine=** _____ obtained on dd / mm / yy **eGFR=** _____ ❑ On Dialysis ❑ Acute Kidney Injury (AKI): for IN-patient/ ED patients only ❑ The patient has **NONE** of the above risk factors.
	Venous Access in situ: ❑ Port ❑ PICC
Previous tests/dates/where?	
Previous Surgery: When?	

MRI SAFETY ASSESSMENT Does the patient have any of the following:			**Comments:**
* Pacemaker *(implant information required)*	❑ Yes	❑ No	
* Cerebral Aneurysm Clips *(implant information required)*	❑ Yes	❑ No	
* Cochlear Implant *(send to implanting hospital)*	❑ Yes	❑ No	
Neurostimulator device	❑ Yes	❑ No	
Insulin/chemotherapy pump	❑ Yes	❑ No	
Vascular stent (indicate location)	❑ Yes	❑ No	
Metal rods, plates, screws, nails	❑ Yes	❑ No	
Ocular implant (cataract lens implant safe)	❑ Yes	❑ No	
Penile implant	❑ Yes	❑ No	
Transdermal Patches	❑ Yes	❑ No	
Ever had metal fragments in eyes?	❑ Yes	❑ No	
Do they work with metal? (i.e. grinder or welder) *(see note below)*	❑ Yes	❑ No	
Any other metallic, magnetic or electronic implants?	❑ Yes	❑ No	
Is the patient pregnant?	❑ Yes	❑ No	
Does the patient have claustrophobia? *(see note below)*	❑ Yes	❑ No	
Allergy to MRI contrast?	❑ Yes	❑ No	

RADIOLOGIST USE ONLY:
Priority: *(please circle)* 1 2 3 4
Is this a specified date (timed) procedure?
If yes, specify date: ____________

Clinical Indications for Scan:
❑ Cancer Staging and/or Diagnosis
❑ Other Diagnosis

❑ Head
❑ Neck
❑ Spine - level
❑ Abdomen/Pelvis - area
❑ Extremity - area
❑ Chest/Cardiac
❑ Breast
❑ Runoff
❑ Contrast

Radiologist/MRT (MR): *(print first, last)*

Radiologist/MRT (MR) signature:

Referring Physician: *(print first, last)*	**CPSO #**	**Date:** dd / mm / yy
Signature:	**Office Phone:** ( )	
Address:	**Fax Number:** ( )	

Note: If sedation is required for claustrophobia, please arrange this with your patient. MRI Department will not dispense sedation. If there is a possibility or history of metal being in your patient's eyes, please arrange for orbit x-rays to confirm or exclude any possible metal in the eyes. Have the x-ray report sent with this requisition. This will help ensure that the patient's MR experience goes smoothly.

The collecting of personal information on this form is done in accordance with Southlake's Privacy Policy. Details are available on our website, www.southlake.ca

SL0274_17 (4/20) "Diagnostic Imaging" Review (5/23)