London Health Sciences Centre

MRI REQUISITION

University Hospital Bookings
Telephone: 519-663-3088
Fax: 519-663-3544

Victoria Hospital Central Bookings
Telephone: 519-685-8770
Fax: 519-667-6826

PATIENT INFORMATION: (Plate)

Name: _____

PIN#: _____

DOB: _____

HC#: _____

Address: _____

Phone: _____

PHYSICIAN INFORMATION:

Print Name (with initials): _____

Signature: _____

Address: _____

Telephone: _____ Fax: _____

☐ INPATIENT ☐ OUTPATIENT

WSIB:

Claim Number: _____

Date of Injury: _____

Employer Address: _____

☐ 3rd PARTY / INSURANCE

EXAMINATION REQUESTED: _____

Clinical Problem: (must be entered) _____

Please make sure all x-rays, bone scans, etc. pertaining to the area being scanned are sent prior to the MRI or with the patient.

MRI RESTRICTIONS: No patients with implanted defibrillators or weight over 350 lbs or 159 kg.
Most pacemakers and pacemaker leads are also contraindicated.

The following must be completed before the MRI will be booked.

1. Does the patient have a history of impaired renal function, or are they currently on dialysis? ☐ Yes ☐ No
2. Does the patient have hypertension? ☐ Yes ☐ No
3. Does the patient have diabetes? ☐ Yes ☐ No
4. Is the patient over 70 years of age? ☐ Yes ☐ No
   Creatinine Value: _____ Date (YYYY/MM/D): _____ *If you answered yes to any of the first 4 questions and your patient requires/or may require Gadolinium (MRI Contrast) a recent creatinine (<3 months) must be forwarded with the requisition.*
5. Does the patient have any of the following implants or clips? ☐ Yes ☐ No
   ☐ Pacemaker ☐ Pacemaker Wires ☐ Defibrillator ☐ Vascular Filter
   ☐ GI Bleed Clip ☐ Carotid Artery Clamp
   ☐ Implanted Electronic Device ☐ Brain Aneurysm Clip ☐ Stents
   ☐ Programmable Shunts ☐ Embolization Coils
   If yes to any of the above, the following information is required.
   Make: _____ Model: _____ Date of Insertion: _____
   Description: _____
6. Has patient ever had metal in his/her eye? If yes, orbital x-ray required. ☐ Yes ☐ No
7. Is the patient pregnant? ☐ Yes ☐ No
8. Has the patient had previous surgery in the area of imaging? ☐ Yes ☐ No
9. Patient weight: _____lb/kg
10. Any previous relevant MRI or CT? ☐ Yes ☐ No
    If yes where/when? _____
11. Does the patient require general anesthetic for their MRI exam? ☐ Yes ☐ No

Are you requesting a timed follow-up procedure (eg. 6 month follow-up)?

If yes, date requested: _____

MRI Exam Date:

-- Radiologist's Use Only --

Booking Priority:

☐ **1** Emergency ☐ **3** Semi Urgent ☐ **4** Non Urgent
☐ **2** Urgent ☐ **3T** Semi Urgent/Timed ☐ **4T** Non Urgent/Timed
☐ **2T** Urgent/Timed

Protocol

For more information on health services in the region, go to www.thehealthline.ca