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

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

Patient Name: *(print first, last)*
Address: Street Number + Name Apartment
City Province Postal Code
Health Card Number: **Version Code:**
Other Insurance:
Home: ( ) **Work/Other:** ( )
Patient not available: From: dd / mm / yy To: dd / mm / yy
Reason:
Area to be scanned:
Diagnostic Question:
Clinical History:

Previous tests/dates/where?
Previous Surgery: When?

Appointment Date: dd / mm / yy
Appointment Time:
Arrival Time:
Hospital Record #:
Date of Birth: dd / mm / yy
Patient Weight: ____________ **kg**

FOR PAEDIATRIC USE ONLY:
Is general anaesthesia required? ❑ Yes ❑ No

RENAL FUNCTION ASSESSMENT
(please check (✔) appropriate)
❑ Hx of Renal Disease ❑ Stroke
❑ On Dialysis ❑ Hypertension
❑ Diabetes ❑ Over 70 yrs of age
❑ Chemotherapy ❑ Gout
❑ Vascular Disease ❑ Cirrhosis

If **YES** to any of the above we require a current creatinine/eGFR (in the last 6 months) attached to the requisition.
❑ The patient has **NONE** of the above risk factors.

Venous Access in situ: ❑ Port ❑ PICC

MRI SAFETY ASSESSMENT Does the patient have any of the following:			**Comments:**
* Pacemaker *(absolute contraindication)*	❑ Yes	❑ No	
* Cerebral aneurysm clips *(absolute contraindication)*	❑ Yes	❑ No	
* Cochlear implants *(absolute contraindication)*	❑ 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)	❑ Yes	❑ No	
Any other metallic, magnetic or electronic implants?	❑ Yes	❑ No	
Is the patient pregnant?	❑ Yes	❑ No	
Does the patient have claustrophobia?	❑ 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
❑ Breast Cancer Screening
❑ 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.

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