

PATIENT INFORMATION					
SURNAME		FIRST NAME		MIDDLE INITIAL	
ADDRESS			CITY	PROVINCE    POSTAL CODE	
MOBILE PHONE #		ALTERNATE PHONE #		EMAIL	
Patient consents to appointment information being disclosed to them via text or e-mail: <input type="checkbox"/> Yes, text <input type="checkbox"/> Yes, email					
SEX ASSIGNED AT BIRTH	GENDER IDENTITY		D.O.B. (YYYY/MM/DD)	HEIGHT (CM)	WEIGHT (KG)
<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other				
HEALTH CARD #		VERSION CODE (VC)	WSIB CLAIM #	OTHER (Self-pay, research, 3rd party payor)	
<input type="checkbox"/> INTERPRETER REQUIRED Preferred language		ACCESSIBILITY CONCERNS OR REQUIREMENTS			
ALTERNATE CONTACT (If not patient)	CONTACT NAME		CONTACT PHONE #		

EXAM INFORMATION AND HISTORY	
TEST/REGION(S) TO BE EXAMINED	REASON FOR EXAM / CLINICAL HISTORY (Please also include presenting symptom(s), relevant underlying diagnosis and therapies, where applicable)
<input type="checkbox"/> <b>TIMED FOLLOW UP</b> <b>DATE REQUESTED</b> (YYYY/MM/DD)  <i>MRI availability is limited; requested dates will be accommodated where possible.</i>	

SCREENING AND PRECAUTIONS	
<b>RENAL ASSESSMENT</b> Impaired renal function? <input type="checkbox"/> Yes <input type="checkbox"/> No On dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No If the answer to any of the above question(s) is yes, then please provide the most recent eGFR results (within the past 6 months) <b>eGFR RESULT</b> (ml/min/1.73 <sup>2</sup> ) <b>DATE COLLECTED</b> (YYYY/MM/DD)  <input type="checkbox"/> Known hypersensitivity to contrast agents <input type="checkbox"/> Currently pregnant <input type="checkbox"/> Currently breastfeeding <input type="checkbox"/> Patient cannot provide reliable medical history or provide consent to contrast injections where applicable <input type="checkbox"/> Requires general anesthesia Rationale:  <i>For patients with claustrophobia requiring oral sedation, the referring provider is responsible for prescribing the medications. Patients taking oral sedation must not drive and should arrange alternative transportation.</i>	<b>POSSIBLE MRI CONTRAINDICATIONS</b> <input type="checkbox"/> Has metal fragments in eye(s)/body <input type="checkbox"/> Cardiac pacemaker or defibrillator <input type="checkbox"/> Eye surgery/injury (excl. lens implants, cataract, or laser surgery) <input type="checkbox"/> Ear surgery/implant <input type="checkbox"/> Implanted stimulators or electrodes <input type="checkbox"/> Any filters, stents, coils, grafts, valves or programmable shunts <input type="checkbox"/> Aneurysm surgery/clips <input type="checkbox"/> Surgery within the last six (6) weeks <input type="checkbox"/> None of the above  <b>Please provide operative report and specify the device information below (include as much detail as possible):</b>  <b>MAKE</b> <b>MODEL #</b>  <b>INSTITUTION WHERE TREATMENT WAS RECEIVED</b>

REFERRING PROVIDER			
PROVIDER NAME		BILLING #	PROFESSIONAL ID
ADDRESS		CITY	PROVINCE    POSTAL CODE
PHONE #	FAX #	COPY TO	
PROVIDER SIGNATURE			DATE

HOSPITAL LOCATION – MUST BE SELECTED			
Select the hospital you would send this patient to, given their diagnostic imaging requirements. <b>Patient will be directed to reasonable nearest hospital with lowest wait times:</b>			
<input type="checkbox"/> Alexandra Marine and General Hospital <input type="checkbox"/> Bluewater Health <input type="checkbox"/> Brant Community Healthcare System <input type="checkbox"/> Brightshores Health System <input type="checkbox"/> Cambridge Memorial Hospital <input type="checkbox"/> Chatham-Kent Health Alliance <input type="checkbox"/> Erie Shores Healthcare	<input type="checkbox"/> Guelph General Hospital <input type="checkbox"/> Haldimand War Memorial Hospital <input type="checkbox"/> Hamilton Health Sciences <input type="checkbox"/> Hanover and District Hospital <input type="checkbox"/> Huron Perth Healthcare Alliance <input type="checkbox"/> Joseph Brant Hospital <input type="checkbox"/> Listowel Wingham Hospital Alliance	<input type="checkbox"/> London Health Sciences Centre <input type="checkbox"/> Niagara Health System <input type="checkbox"/> Norfolk General Hospital <input type="checkbox"/> South Bruce Grey Health Centre <input type="checkbox"/> St Joseph's Health Care - London <input type="checkbox"/> St Joseph's Healthcare – Hamilton <input type="checkbox"/> St Thomas-Elgin General Hospital	<input type="checkbox"/> Strathroy Middlesex General Hospital <input type="checkbox"/> Tillsonburg District Memorial Hospital <input type="checkbox"/> Waterloo Regional Health Network <input type="checkbox"/> Wellington Health Care Alliance <input type="checkbox"/> Windsor Regional Hospital <input type="checkbox"/> Woodstock Hospital
<input type="checkbox"/> <b>Patient must go to selected hospital. This may result in longer wait times.</b>			

OFFICE USE ONLY			
PRIORITY <input type="checkbox"/> P1 <input type="checkbox"/> P2 <input type="checkbox"/> P3 <input type="checkbox"/> P4	TIMED <input type="checkbox"/> YES <input type="checkbox"/> NO	SPECIFIED DATE	
CCO	PROTOCOL	RADIOLOGIST	