



OUTPATIENT MRI REQUISITION FORM

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, e-mail					
SEX ASSIGNED AT BIRTH	GENDER IDENTITY		DOB (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 NUMBER (HN)		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 TO BE EXAMINED (Choosing Wisely checklists MUST accompany referrals where appropriate)		REASON FOR EXAM / CLINICAL HISTORY (Please also include presenting symptom(s), relevant underlying diagnosis and therapies, where applicable)
<input type="checkbox"/> TIMED FOLLOW UP	DATE REQUESTED (YYYY/MM/DD)	MRI availability is limited; requested dates will be accommodated where possible.

SCREENING & PRECAUTIONS		
RENAL ASSESSMENT 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 3-6 months) eGFR RESULT (ml/min/1.73 ²) DATE COLLECTED (YYYY/MM/DD)		POSSIBLE MRI CONTRAINDICATIONS <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 Please provide operative report and specify the device information below (include as much detail as possible): MAKE _____ MODEL NO. _____
<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>		INSTITUTION WHERE TREATMENT WAS RECEIVED REFERRING PROVIDER

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

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	<input type="checkbox"/> Cancer	<input type="checkbox"/> No	PROTOCOL					RADIOLOGIST