Ontario
South West Local Health Integration Network

Choosing Wisely Canada™

MRI REQUISITION – this form can be found on www.swpca Check one Site:

☐ Grey Bruce Health Services - Owen Sound	F: 519-376-3952	☐ LHSC – VH /Children's	F: 519-667-6826
☐ Huron Perth Health Care Alliance - Stratford	F: 519-272-8247	☐ St. Joseph's Health Care London	F: 519-646-6025
☐ LHSC - UH	F: 519-663-3544	☐ Woodstock Hospital	F: 519-421-4238

PATIENT INFORMATION:

Surname: _____ First Name: _____ Middle Initial: _____

Gender: ☐ M ☐ F ☐ X Date of Birth (YYYY-MM-DD): _____

Street Address: _____ Apt: _____ City: _____ Province: _____ Postal Code: _____

Health Card No. : _____ Version Code: _____ Research or 3rd Party No.: _____

Telephone (Day): _____ (Evening): _____ (Cell): _____

☐ Outpatient ☐ Long Term Care ☐ Inpatient ☐ ED

WSIB: ☐ Y ☐ N _____ WSIB No.: _____ Date of Injury (YYYY-MM-DD): _____

Mobility: ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Mechanical Lift Preferred Language: ☐ EN ☐ OTHER _____

Y N	Please check the following:
☐ ☐	Breast feeding
☐ ☐	History of cancer
☐ ☐	Medication patch (Foil)
☐ ☐	Piercings (Remove prior to exam)
☐ ☐	Pregnant __ wks.
☐ ☐	Shrapnel or bullets
☐ ☐	Surgery in last 6 wks.
☐ ☐	Tattoos

Precautions:

☐ TB ☐ MRSA ☐ VRE ☐ Shingles

Y N	Contrast Risk Factors
☐ ☐	Diabetic
☐ ☐	Hypertension
☐ ☐	Impaired renal function
☐ ☐	MRI contrast reaction
☐ ☐	On dialysis
☐ ☐	Gout
☐ ☐	Protein in Urine
☐ ☐	Kidney Surgery

_____

If one or more of the above is Y provide serum creatinine result within last 6 months:

_____

YYYY-MM-DD

Y N	Possible MRI Contraindications
☐ ☐	History of Metal in Eye (*X-ray may be required)*
☐ ☐	Aneurysm surgery*
☐ ☐	**Cardiac pacemaker or defibrillator***
☐ ☐	Cochlear or Ocular Implants*
☐ ☐	Coils, filters, grafts, stents *
☐ ☐	Electronic devices, implanted or not implanted*
☐ ☐	Heart valve*
☐ ☐	Implanted stimulators, electrodes or pumps*
☐ ☐	Shunts: ☐ Programmable* ☐ Non-Programmable*
☐ ☐	Other: _____

*Please forward surgical report and specify the:

Make/Model: _____ **Date:** _____

Institution of surgery: _____

☐ Y ☐ N Surgery in exam area ☐ Y ☐ N Timed ☐ Y ☐ N Relevant reports attached **HEIGHT** _____ **CM/FT WEIGHT** ___ **KG/LBS**

REFERRING PHYSICIAN:

Last Name: _____ First Name: _____ **Signature:** _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Telephone: _____ Fax: _____ Billing No.: _____

COPY TO: _____

EXAMINATION REQUESTED: _____ **Working Diagnosis:** _____

CLINICAL INFORMATION: ☐ **Y** ☐ **N Recent trauma**

Considerations: ☐ Claustrophobia ☐ Mild Sedation (not provided) ☐ General Anaesthesia ☐ Paediatric ☐ Interpreter Required

OFFICE USE ONLY

Protocol:

☐ P1 ☐ P2 ☐ P3 ☐ P4 ☐ Timed ☐ Contrast

X-rays required: ☐ Y ☐ N Staff Initials: _____

Appointment Date and Time: _____

☐ Prep: NPO 4 hours prior to arrival

☐ No prep

NOTE: This requisition may be booked at an alternate site in the South West LHIN to improve patient access.