

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)
<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) <i>MRI availability is limited; requested dates will be accommodated where possible.</i>					
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) <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>			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 <div style="color: red; font-weight: bold; padding-top: 10px;"> Please provide operative report and specify the device information below (include as much detail as possible): </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div>MAKE</div> <div>MODEL NO.</div> </div> <div style="margin-top: 20px;"> INSTITUTION WHERE TREATMENT WAS RECEIVED </div>		
REFERRING PROVIDER					
PROVIDER NAME			BILLING #		PROFESSIONAL ID
ADDRESS			CITY	PROVINCE	POSTAL CODE
PHONE #		FAX #		COPY TO	
PROVIDER SIGNATURE					DATE

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