ST. JOSEPH'S
UNITY HEALTH TORONTO

MAGNETIC RESONANCE IMAGING (MRI) OUTPATIENT REQUISITION

St. Joseph's Health Centre
Diagnostic Imaging Department
30 The Queensway, Toronto ON

Bookings Only: 416-530-6169
General Calls: 416-530-6001
Fax Line: 416-530-6060

Name:______________________
Male ☐ Female ☐
MRN:______________________
DOB:______________________
Address:______________________
____
Telephone:______________________
OHIP #:______________________

INCOMPLETE FORMS WILL BE RETURNED AND NOT BE PROCESSED

Area to be Scanned (be specific):______________________

STUDY PRIORITY: ☐ **STAT/TODAY (Call MRI Radiologist)** ☐ **URGENT** ☐ **ROUTINE** **WSIB/Third Party Claim Number:**______________

CURRENT PATIENT LOCATION: ☐ **EMERGENCY** ☐ **Inpatient** ☐ **Clinic/ACC** ☐ **Outpatient**

CLINICAL HISTORY

Isolation Precautions: ☐ **N/A** ☐ **Contact** ☐ **Droplet** ☐ **Airborne** ☐ **Reverse**

MANDATORY INFORMATION (MUST BE COMPLETED PRIOR TO SUBMISSION)

Is the patient on Dialysis? ☐ YES ☐ NO

Previous allergic reaction to a MR contrast agent ☐ YES ☐ NO

Operative report required for all surgeries listed below:

Head: Brain	☐ YES	☐ NO
Eye	☐ YES	☐ NO
Ear	☐ YES	☐ NO
Chest/Heart	☐ YES	☐ NO

Type and date of other surgeries. ***Operative report required for all implants including model make and number for MR Safety reasons.

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PATIENT SCREENING

Cardiac Pacemaker or pacing wires ☐ YES ☐ NO

**** If yes to above, then contraindication to MR exam****

Aneurysm Clip	☐ YES	☐ NO
Heart Valve Replacement	☐ YES	☐ NO
Neuro-stimulator or residual wires	☐ YES	☐ NO
Cochlear Implant	☐ YES	☐ NO
Intrauterine Device	☐ YES	☐ NO
Hearing Aid	☐ YES	☐ NO
Medication Patches	☐ YES	☐ NO
Shrapnel or Bullets	☐ YES	☐ NO
Surgical Rods or Staples	☐ YES	☐ NO
Prosthesis (limb, joint, eye, ear)	☐ YES	☐ NO
Body Piercing/Jewellery	☐ YES	☐ NO
Other Implanted Devices:	☐ YES	☐ NO

Model make and number___________________

Have you EVER cut, welded or ground metal?	☐ YES	☐ NO
Have you EVER had metal in your eye?	☐ YES	☐ NO
Since your last MR exam?	☐ YES	☐ NO
Is there a chance that you might be pregnant?	☐ YES	☐ NO
Are you claustrophobic?	☐ YES	☐ NO

Does the patient consent to appointment information being disclosed in a telephone message?	☐ YES	☐ NO
Is patient able to come on short notice?	☐ YES	☐ NO
Lift Device Required?	☐ YES	☐ NO
Sign Language Interpreter Required?	☐ YES	☐ NO
Other Language Interpreter Required?	☐ YES	☐ NO
Referring Physician: If patient requires X-ray to rule out metallic foreign bodies, do you give permission for the X-rays?	☐ YES	☐ NO

Height:__________ **Weight:**__________

REQUESTING PHYSICIAN

Physician Name:______________________
Physician Specialty:______________________
Address:______________________
____

Telephone Number:______________
Pager Number:______________
Fax:______________
Copies to:______________

DATE/TIME	**Physician Signature**	**Physician's Name (Please Print)**
DD / Month / YYYY ____:___ h		