Request for MRI

HUMBER RIVER HOSPITAL

Wilson Avenue Site
1235 Wilson Avenue, 2nd Floor
Toronto, ON M3M 0B2
TEL. (416) 242-1000 EXT 63500
FAX (416) 242-1079

Department Use Only Appointment Location	WILSON SITE
Appointment Date	
Appointment Time	

Last Name | First Name | Health Card No.

Address (**Street**, **City**, **Postal Code**)

❑ M ❑ F

Date of Birth (d/m/y) | Home Phone | Other Phone

EXAM REQUESTED:

Clinical Indication for Exam:

Preliminary Diagnosis: | Allergies:

Creatinine (Collection Date **MUST** Be Provided) | Height (cm): | **Weight** (kg):

List **ALL** Previous Imaging (**Attach Reports**):

❑ Inpatient Room No. Unit Ext. ❑ Ambulatory ❑ Wheelchair ❑ Stretcher ❑ Bed ❑ O2 ❑ IV

❑ WSIB ❑ Other Insurance Claim/Policy No. Contact:

Do you have any of the following…	Yes	No		Yes	No
ANY injury **EVER** to your eye involving a metallic foreign object			**ANY** orthopaedic hardware, including joint replacement		
ANY metallic foreign object (eg., bullets, shrapnel)			**ANY** type of prosthesis (eg., limb, ocular, penile)		
Cardiac pacemaker or implanted cardioverter defibrillator			Intrauterine device (IUD), diaphragm, or pessary		
Intracranial aneurysm clips			Medication patch (eg., nicotine, nitroglycerine)		
Surgical staples, clips, or metallic sutures			Tattoo, permanent makeup, or body piercing jewellery		
Metallic filter, stent, or coil			Dentures, braces, retainers, or partial plates		
VP or programmable shunt			Cochlear or inner ear implant		
Neurostimulator or drug infusion pump			A known reaction to MRI contrast material		
Electronically or magnetically activated device or implant			A history of kidney disease, kidney failure, or kidney transplant		
Vascular access port or catheter			Is there **ANY** chance you may be pregnant		
Artificial heart valve			**Are you claustrophobic**? If YES, your referring or family doctor **must** prescribe oral conscious sedation, and you **must** bring a driver with you to take you home after your test		
Tissue expander					

If **YES**, List **ALL** Implants Including **Make** and **Model Number**:

List **ALL** Previous Surgeries:

Patient's Signature × _____

Physician's Name (Please PRINT) _____

Address _____

_____

Phone _____

Fax _____

Physician's Signature × _____

Department Use Only

Priority

❑ 1. Emergent ❑ 2. Inpatient/Urgent
❑ 3. Cancer Staging ❑ 4. Semi/Non-urgent
❑ Timed Procedure/Wait Times Specified

Clinical Indication

❑ BC Breast Cancer Screening
❑ SD Cancer Staging and/or Diagnosis
❑ OT Other

❑ 1.5T ❑ 3T

Coding _____

Radiologist's Signature × _____

Form # 103101, version (10/17)

INCOMPLETE, ILLEGIBLE, AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED - TABLE WEIGHT LIMIT IS 227kg (500lbs)