Request for MRI

Humber River Hospital
1235 Wilson Ave. **LEVEL 2 EAST**
Toronto, ON M3M 0B2
Phone 416-242-1000 Ext. 63500 ***Fax*** 416-242-1079

Appointment Information

Date ____________ **Time** ____________

Patient Information

Name ____________

OHIP # ____________ VC ____________

DOB (d/m/y) ____________ Sex ☐ M ☐ F

Address ____________

City ____________ PC ____________

Phone ____________

WSIB Claim # ____________

Area to be Scanned

____

Clinical Information

____

Does Your Patient Have Any of the Following MRI Safety Risks? (**<u>Must</u> be Completed - Especially Kidney Questions**)	**Yes**	**No**
Possibility That You Are Pregnant		
Any Injury Ever to Your Eye(s) From a Metal Object		
Any Injury Ever From a Metal Object (eg., Bullet, Shrapnel)		
Cardiac Pacemaker, Implanted Cardioverter Defibrillator		
Intracranial Aneurysm Clips		
Surgical Staples, Surgical Clips, Metallic Sutures		
Metallic Filter, Stents, Coils, Shunt		
Neuro/Bio-Stimulator, Drug Infusion Pump		
Electronically or Magnetically Activated Device		
Vascular Access Port, Catheter		
Artificial Heart Valve		
Tissue Expander		
Orthopedic Hardware (eg., Joint Replacement)		
Prosthetic Device (eg., Limb, Penile, Eye, Ear)		
Intrauterine Device, Diaphragm, Pessary		
Body Art (eg., Tattoos, Permanent Makeup, Body Piercings)		
Dental Appliance (eg., Dentures, Braces, Retainer, Plates)		
Medication Patch (Specify) ____________		
Claustrophobia (Referring Doctor is Responsible for Sedation)		
Acute Renal Failure		
Chronic Kidney Disease		
On Dialysis		

If Yes, Please Indicate Dialysis Day(s) And Time

☐ **Mo** ☐ **Tu** ☐ **We** ☐ **Th** ☐ **Fr** **Time**: ____________

Supplementary Information

Height ________ cm **Weight** ________ kg

Table Weight Limit is 227 kg/500 lbs

Transportation Requirements

☐ Ambulatory ☐ Wheelchair ☐ Other ________

Creatinine ________ µmol/L

Blood Collection Date (d/m/y) ________

Allergies ________

Previous Imaging (Reports <u>Must</u> be Attached)

☐ MRI ☐ CT Scan ☐ X-Ray
☐ Ultrasound ☐ Angiogram ☐ Nuclear Medicine

Previous Surgeries (Reports <u>Must</u> be Attached)

☐ Head/Neck ________
☐ Spine ________
☐ Heart/Chest ________
☐ Abdomen/Pelvis ________
☐ Extremities ________

Implant/Device Details

Make ________ Model ________
Date Implanted (d/m/y) ________
Make ________ Model ________
Date Implanted (d/m/y) ________

Patient Signature ________

Referring Doctor Information

Name (PRINT) ________
Address ________
City ________ PC ________
Phone ________ Fax ________
Signature ________
CPSO # ________ Billing # ________

Department Use Only

Priority ☐ P1 ☐ P2 ☐ P3 ☐ P4
Clinical Indication ☐ OT ☐ SD ☐ Timed
Radiologist Code ________
Radiologist Signature ________
MRT Code ________ ☐ 1.5T ☐ 3T
MRT Signature ________

INCOMPLETE, ILLEGIBLE AND/OR UNSIGNED REQUISITION FORMS WILL BE RETURNED

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