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? (Must 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		
Programmable Shunt		
Metallic Filter, Stents, Coils		
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 / Device (Specify) _____		
Claustrophobia (Referring Doctor is Responsible for Sedation)		
Acute Renal Failure		
Chronic Kidney Disease		
On Dialysis		

If On Dialysis, Please Indicate Dialysis Day(s) and Time

☐ **Mon** ☐ **Tue** ☐ **Wed** ☐ **Thu** ☐ **Fri** **Time**: _____

Referring Doctor Information

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

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 Must be Attached**)

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

Previous Surgeries (**Reports Must 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 _____

Department Use Only

Priority P1 ☐ P2 ☐ P3 ☐ P4 ☐ Timed

☐ Buscopan IV 30 mg (if Buscopan is contraindicated, use Glucagon IV 2 mg)

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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