



# MRI REQUISITION

## PATIENT INFORMATION

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Sex ☐ F ☐ M ☐ Other  
Last name, First name DD-MMM-YYYY  
Health card \_\_\_\_\_ Version code \_\_\_\_\_ Hospital MRN \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Postal code \_\_\_\_\_ Phone 1 \_\_\_\_\_ Phone 2 \_\_\_\_\_  
Preferred Alternate

## SCREENING

### PRECAUTIONS

Patient weight (Max 250 kg)..... ☐ kg / ☐ lbs  
Hemodialysis ..... ☐ Y ☐ N  
*If yes and receiving gadolinium, dialysis must be arranged same day*  
Peritoneal dialysis ..... ☐ Y ☐ N  
*If yes and receiving gadolinium, prescription may need alteration*  
Claustrophobia requiring sedation ..... ☐ Y ☐ N  
*If yes, referring physician to provide sedation*  
Chance of pregnancy ..... ☐ Y ☐ N

### MR SAFETY – completed with patient

Previous eye injury involving metal ..... ☐ Y ☐ N  
*If yes, orbits x-ray report must be attached*

### Does patient have:

Pacemaker, defibrillator, implanted cardiac leads .... ☐ Y ☐ N  
Cochlear (ear) implant ..... ☐ Y ☐ N  
Aneurysm clips, coils, or stents ..... ☐ Y ☐ N  
Artificial heart valve ..... ☐ Y ☐ N  
Infusion pump or neurostimulator ..... ☐ Y ☐ N  
Any other surgical implantable device/prosthesis .... ☐ Y ☐ N  
Shrapnel/bullets ..... ☐ Y ☐ N  
*Manufacturer and model number of implantable devices required*

Any previous surgery to ears, eyes, brain, or heart ..... ☐ Y ☐ N

Any medical procedure or surgery in last 6 weeks ..... ☐ Y ☐ N

Provide details of MR safety (and attach relevant operative notes):

## REGION TO BE EXAMINED

### REQUESTED PRIORITY

☐ Routine ☐ Urgent | ☐ Specific date/timeframe \_\_\_\_\_  
DD-MMM-YYYY

### CLINICAL INDICATION/RELEVANT HISTORY

Relevant previous imaging reports must be attached

## BILLING

☐ OHIP ☐ WSIB claim # \_\_\_\_\_ ☐ Other \_\_\_\_\_

## REFERRING PHYSICIAN

Name, address, fax, phone, billing number:

Send copies to:

☐ MR Safety questions have been reviewed with patient  
**MANDATORY**

Signature **X** \_\_\_\_\_ Date \_\_\_\_\_  
DD-MMM-YYYY