St. Michael's

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Patient ID

MRI Requisition Form

Is patient able to come in for a midnight appointment?
(Monday - Friday between 11 pm to 6 am) Yes ☐ No ☐

Tel: 416-864-5661 Fax completed form to 416-864-5820

Patient Name: (Please Print)		DOB: (D/M/Y)	MRN:
Address:		☐ Male ☐ Female	Weight: (Kg)
Health Card No:	VC:	Home Tel:	Mobile/Work Tel:

Physician Name: (Please Print)		CC Copies To:
Phys Tel:	Phys Fax:	Phys Billing #:

Area to be Scanned: (Please be specific) ___________________________________

Clinical Information:

The following can interfere with the MR Imaging and/or can be a safety hazard. If the following information changes between now and the appointment notify the MRI Department. **Inaccurate information can result in appointment cancellation the day of exam**.

	Yes	No		Yes	No
1. Has the patient ever had an MRI?			6. Is the patient diabetic?		
2. Has the patient ever had a penetrating eye injury which required a metal fragment/object to be removed by a physician?			7. Does the patient have a history of kidney dysfunction or have a single kidney?		
3a. Has the patient worked with metal (professionally or hobby) as a welder, metal grinder or metal cutter?			8. Is the patient over the age of 70?		
3b. If yes, since the previous MRI? (If applicable)			9. Is the patient claustrophobic? Sedation must be brought with the patient and he/she must have an accompanying escort. MRI will not prescribe nor dispense.		
3c. If yes, was eye protection always worn?			10a. Will the patient require an interpreter? 10b. If yes, for which language? ______________________		
4. Is the patient pregnant or breastfeeding?					

5. Indicate if the patient has the following:	Yes	No		Yes	No
Cardiac pacemaker or pacing wires (epicardial)			Artificial heart valve		
Implanted defibrillator (ICD)			Breast tissue expander		
Neurostimulator/TENS unit			Penile implant		
Cochlear (middle ear) implant			Shrapnel, bullet, BB pellet foreign body		
Brain aneurysm clip			Drug infusion pump		
Intravascular stent, filter, coil			Other metallic implants?		

List all previous surgeries and implants:

Include date and location of the surgery to ensure compatibility. Implant serial numbers may be requested.

I attest that the contents of this form are verified and the procedure has been explained to the patient including the possibility of the use of contrast agents.

Physician's Signature: ______________________ **Date: ______________**

Incomplete and/or illegible forms will be returned resulting in a delay of appointment booking.

For MRI Dept App't Date: App't Time: Scanner:

Form No. 69240 Dev. 03/16/2011 Rev. 09/13/2012

MRI REQUISITION FORM