MRI REQUEST

Sinai Health System
Tel: 416-586-4941
Fax: 416-586-4797

UHN — Toronto General, Toronto Western, Princess Margaret, Toronto Rehab, Michener Institute
Tel: 416-946-2026
Fax: 416-946-2296

WCH — Women's College Hospital — Health care for women | REVOLUTIONIZED
Tel: 416-323-7515
Fax: 416-323-6316

Patient Information

Medical Record No.: _____ Health Card No.: _____ Version Code: _____

Name: _____ _____ DOB: _____/_____/_____ Sex: ❒ M ❒ F
First Name *Last Name* *day* *month* *year*

Address: _____ City: _____ Prov.: _____ Postal Code: _____

Home Tel.: _____ Cell: _____ Business Tel.: _____

Mobility Status: ❒ Walking ❒ Wheelchair ❒ Stretcher ❒ Ambulance Additional Info.: _____

Billing Information: ❒ OHIP ❒ WSIB ❒ Non Resident/Other Claim Number/Insurance No.: _____
(include attachments if necessary)

For MRI Use Only | Booking Date:

To be completed by Patient

FOR PATIENT SAFETY THESE QUESTIONS MUST BE ANSWERED:

YES	NO	
❒	❒	Have you had a previous MRI?
❒	❒	Has metal ever gone into your eye?
❒	❒	Do you have any kidney disease?
❒	❒	Are you on dialysis?
❒	❒	Could you be pregnant?

Date of last Menstrual Period: _____

What is your current Weight: _____
(maximum allowable weight 550lbs./250kg, but dependent on girth)

What is your current Height: _____

Do you have any of the following?
(include reports for each implant device)

YES	NO	
❒	❒	Aneurysm Clips
❒	❒	Artificial Cardiac Valve
❒	❒	Cardiac Pacemaker
❒	❒	Cochlear Implants
❒	❒	Coils/Stents
❒	❒	Neurostimulator
❒	❒	Retained Pacing Wires
❒	❒	Shrapnel / Bullets

Other Implanted Devices:
_____
(add additional pages if necessary)

Have you ever had surgery on your?
(check all that apply)

- ❒ Abdomen / Pelvis
- ❒ Arms / Legs
- ❒ Chest
- ❒ Head
- ❒ Neck
- ❒ Spine

Name all surgeries and approximate year of surgery:
_____
_____
_____
_____
_____
_____

Patient's Signature: X _____

Referring Provider Information

Provider's Name: _____

Address: _____

_____ Postal Code: _____

Phone: _____ Fax: _____

Billing No.: _____ CPSO: _____

Completed Tests and Associated Results

Sites: ❒ MSH ❒ PMH ❒ TGH ❒ TWH ❒ WCH ❒ Outside Hospital/Clinic *(if from outside hospital, attach outside report)*

Tests: _____

_____

Does the patient require an interpreter? ❒ Yes ❒ No If yes, what language? _____

Exam Information

Area to be Scanned ***(be specific):*** _____

_____

Clinical Information / Working Diagnosis:

_____

_____

_____

_____

Location:

IMPORTANT INSTRUCTIONS for Referring Physicians

If the patient has impaired renal function, you must submit a serum creatinine done within 3 months of the MRI appointment. For many implanted devices it is absolutely critical **TO LIST THE MANUFACTURER AND MODEL NUMBER** to ensure that the patient is not harmed in the magnet. For more information, see supplementary info sheet. Submit all surgical reports available.

Provider's Signature: X _____ Date: _____

INCOMPLETE/ILLEGIBLE REQUESTS WILL BE RETURNED/FAXED BACK WITHOUT AN APPOINTMENT
FORM MUST BE COMPLETE, INCLUDING PATIENT AND PHYSICIAN SIGNATURES