MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex
Tel: 416-586-4941
Fax: 416-586-4797

University Health Network
Toronto General Hospital | Toronto Western Hospital | Princess Margaret Hospital
Tel: 416-946-2026
Fax: 416-946-2296

WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED
Tel: 416-323-7515
Fax: 416-323-6316

MRI REQUEST

For MRI Use Only | Booking Date:

Patient Information

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

Name:_____ _____ DOB: _____/ _____/ _____ Sex: ☐ M ☐ F
First Name *Last Name* *dd* *mm* *yyyy*

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)

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?
(check all that apply)

- ☐ 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: _____ _____ _____

Approximate year of surgeries *(add additional pages if necessary)*: _____ _____

Patient's Signature: X _____

Referring Physician Information

Physician's Name: _____

Address:_____

_____Postal Code:_____

Phone: _____ Fax: _____

Exam Information

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

Clinical Information /Working Diagnosis:

_____ _____ _____ _____ _____

Location

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?_____

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.

Physician's Signature: X _____ Date: _____

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