MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex

University Health Network
Toronto General Hospital Toronto Western Hospital Princess Margaret Hospital

WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

MRI REQUEST

Mount Sinai Hospital	University Health Network	Women's College Hospital
Tel: 416-586-4941	Tel: 416-946-2026	Tel: 416-323-7515
Fax: 416-586-4797	Fax: 416-946-2296	Fax: 416-323-6316

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?
(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: ____________

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 ____________________

For MRI Use Only | Booking Date:

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. 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