MOUNT SINAI HOSPITAL
Joseph and Wolf Lebovic Health Complex
600 University Avenue,
Toronto, Ontario, Canada M5G 1X5

Medical Imaging Request Form

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Clearly imprint patient identification card

Bring this form, your Ontario Health Card and your Mount Sinai Hospital Card to your Medical imaging examination.

If you don't have a Hospital Card then first go to the main floor Admitting Department to obtain your own card.

✔ Modality ALL AREAS ARE SCENT FREE	Floor or Location	Telephone	Fax
☐ X-Ray (General Imaging)	5th floor	416-586-4411	416-586-8866
☐ Angiography, Gastrointestinal, Interventional	5th floor	416-586-4800, ext. 4418	416-586-8555
☐ Breast Imaging (Mammography)	Marvelle Koffler Breast Centre, 12th floor	416-586-4422	416-586-4714
☐ Nuclear Medicine	6th floor, Room 6-201	416-586-4446	416-586-8790
☐ Ultrasound	5th floor	416-586-4450	416-586-1569
For Obstetric Ultrasound use the CEOU *(Centre of Excellence in Obstetric Ultrasound)* request form	Ontario Power Generation Building 700 University Avenue, 3rd floor	416-586-8556	416-586-8405
For MRI use the *Magnetic Resonance Imaging* request form	60 Murray Street & 5th floor	416-586-4941	416-586-4797
For CT use the *Computed Tomography Imaging* request form	5th floor	416-586-4800, ext. 4418	416-586-3180

PATIENT INFORMATION: INCOMPLETE REQUISITIONS WILL BE RETURNED

BIRTHDATE YYYY MM DD

HOSPITAL MEDICAL RECORD NO.

SURNAME

GIVEN NAME

ADDRESS (Street, Apt #)

CITY/TOWN PROVINCE POSTAL CODE

TELEPHONE (Area Code & No.)

Health Card Number Version Code

Exam Requested

Date of Request
Y Y Y Y M M D D

Clinical History and Indication

Allergies ☐ Yes ☐ No
If YES, specify _____

Diabetic ☐ Yes ☐ No

MS275

REFERRING PHYSICIAN INFORMATION

Name and Initials (Print):

Doctor's Signature: REQUIRED

Telephone #: ( )

Fax #: ( )

Requested Appointment Date (if applicable):

Billing & CPSO # REQUIRED

Mailing Address:

MEDICAL IMAGING USE ONLY

RADIOLOGIST SIGNATURE:	APPOINTMENT DATE (YYYY MM DD)	PROTOCOL:
RADIOLOGIST NAME (PRINT):	APPOINTMENT TIME (24 hr clock) (HH:MM)	