

# MRI Requisition

IN PATIENT  OUT PATIENT  EMERGENCY

Patient Name: <i>(print last, first)</i>		Appointment Date: ____/____/____ yyyy      mm      dd	
Address: #	Street:	Apt:	Appointment Time:
City/Town:	Province:	Postal Code:	Arrival Time:
Health Card Number:		Version Code:	Hospital Record #:
Other Insurance:		WSIB Number:	Date of Birth: ____/____/____ yyyy      mm      dd
Home: (    )		Work/Other: (    )	Patient Weight:
<b>AREA TO BE SCANNED:</b>  <b>DIAGNOSTIC QUESTION:</b>  <b>CLINICAL HISTORY:</b>		<b>FOR PAEDIATRIC USE ONLY:</b> Is general anesthesia required? <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>RENAL RISK FACTORS</b> (please check (✓) appropriate)  <input type="checkbox"/> Hx of Renal Disease <input type="checkbox"/> Stroke <input type="checkbox"/> On Dialysis <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Over 60 yrs of age <input type="checkbox"/> Chemotherapy for malignancy <input type="checkbox"/> Vascular Disease  If <b>YES</b> to any of the above we require a current creatinine/eGFR (in the last 3 months) attached to the requisition.  <input type="checkbox"/> The patient has none of the above risk factors	
Previous tests/dates/where?			
Previous Surgery:		When?	
<b>Does the patient have any of the following:</b>			
* Pacemaker (epicardial pacewires)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
* Cerebral aneurysm clips	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
* Cochlear implants	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Prosthetic heart valve	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Neurostimulator device	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Insulin/chemotherapy pump	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Coronary bypass graft; vascular stent	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Metal rods, plates, screws, nails	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Ocular implant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Penile implant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Transdermal Patches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Ever had metal fragments in eyes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do they work with metal? (i.e. grinder or welder)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Any other metallic, magnetic or electronic implants?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, explain:			
Is the patient pregnant?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the patient have claustrophobia?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
* Is an Absolute contraindication			
Referring Physician: <i>(print first, last)</i>		Address:	
Signature:		Office Phone: (    )	
		<b>RADIOLOGIST USE ONLY:</b> <b>Priority:</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> T2 <input type="checkbox"/> T3 <input type="checkbox"/> T4 <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Spine - level <input type="checkbox"/> Abdomen/Pelvis - area <input type="checkbox"/> Extremity - area <input type="checkbox"/> Chest/Cardiac <input type="checkbox"/> Breast <input type="checkbox"/> Runoff <input type="checkbox"/> Contrast Specify series required: _____ _____ _____	



**Note:**  
If sedation is required for claustrophobia, please arrange this with your patient. York Central Hospital MRI will not dispense sedation. If there is a possibility or history of metal being in your patient's eyes, please arrange for orbit x-rays to confirm or exclude any metal currently in the eyes. Have the x-ray report sent with this requisition. This will help ensure that the patient's MRI experience goes smoothly.