**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

| Tel: 416-586-4941 | Tel: 416-946-2026 | Tel: 416-323-7515 |
|---|---|---|
| Fax: 416-586-4797 | Fax: 416-946-2296 | Fax: 416-323-6316 |

*(right margin, vertical text)* 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 | Exam Information |
|---|---|

**Exam Information**

Physician's Name: _____

Address: _____

_____ Postal Code: _____

Phone: _____  Fax: _____

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

**Clinical Information /Working Diagnosis:**
_____
_____
_____
_____

**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? _____

*(right margin, vertical text)* Location

## IMPORTANT INSTRUCTIONS for Referring Physicians

If the patient has impaired renal function, you must submit a serum creatinine done <u>within 3 months</u> 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**