Mackenzie Health

Mackenzie Richmond Hill Hospital
10 Trench Street
Richmond Hill, Ontario
L4C 4Z3

MRI Requisition

Tel: 905-883-2004 / 905-832-4554 Ext. 2004
Fax #: 905-883-2043

Referring Physician:	
Billing#:	
Referring Physician Signature:	
Additional Reports to:	
Referring Physician Address:	
Referring Physician Office Phone: ( )	
Referring Physician Fax: ( )	

☐ **Other Insurance/ WSIB#** _____

MRN: _____

Patient Name: *(Print Last, First)*

Address: # *Street* *Apt:* *City/Town:* *Province* *Postal Code:*

Health Card Number: **Version Code:** **Date of Birth:** *dd/mm/yyyy*

Primary Number: ( ) ☐ **Cell** ☐ **Home** ☐ **Work ( )**

Secondary Phone Number: ( ) ☐ **Cell** ☐ **Home** ☐ **Work ( )**

Clinical History and Diagnostic Question: ☐ Cancer diagnosis or staging?

Specified exam date requested? _____

EXAM REQUIRED (check all that apply)

Brain
- ☐ Brain Routine
- ☐ Brain MS
- ☐ Seizure
- ☐ Brain & MRA COW
- ☐ IAC
- ☐ MRV Head
- ☐ Orbits
- ☐ Sella/Pituitary

Spine
- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar
- ☐ Sacrum/Coccyx
- ☐ Lumbosacral Plexus
- ☐ Sacroiliac Joints
- Whole Spine
  - ☐ Cord Compression
  - ☐ Metastases

Abdomen
- ☐ Liver
- ☐ MRCP
- ☐ Pancreas & MRCP
- ☐ Spleen
- ☐ Adrenals
- ☐ Kidneys
- ☐ PCKD (renal size only)

Angiogram (with Gadolinium)
- ☐ Subclavians (Bilateral)
- ☐ Renal/Mesenteric
- ☐ Thoracic Outlet
- ☐ Peripheral Runoff
- ☐ Thoracic Aorta ☐ Abdominal Aorta
- ☐ Carotid/Vertebrals ☐ Dissection

Head and Neck
- Brachial Plexus ☐ Right ☐ Left
- ☐ Neck (soft tissue)
- ☐ Parathyroids
- ☐ TMJs
- ☐ Parotids

Chest and Breast
- Breast ☐ Mass/Follow-up
- ☐ Implant
- Chest Mass ☐

Pelvis
- ☐ Pelvis
- ☐ Rectal Mass
- ☐ Anal Fistula
- ☐ Testicular Mass
- ☐ Urethra (Female or Posterior Male)

Other Request
- Specify:

Musculoskeletal (Upper Extremity)

Shoulder	☐ R	☐ L
Elbow	☐ R	☐ L
Hand/Wrist (Inflam. Arthritis)	☐ R	☐ L
Wrist	☐ R	☐ L
Thumb/Finger - Specify:		

Musculoskeletal (Lower Extremity)

Hip	☐ R	☐ L
Pelvis (Bony)	☐ R	☐ L
Hamstring (Proximal)	☐ R	☐ L
Knee	☐ R	☐ L
Ankle/Hindfoot	☐ R	☐ L
Achilles Only	☐ R	☐ L
Forefoot (Osteomyelitis)	☐ R	☐ L
Hindfoot (Osteomyelitis)	☐ R	☐ L
Forefoot (Inflammatory)	☐ R	☐ L
Forefoot Other (e.g. Morton's)	☐ R	☐ L

Palpable Lump Work Up (With Markers)

Upper Extremity	☐ R	☐ L
Specify:		
Lower Extremity	☐ R	☐ L
Specify:		
Body/Other	☐	
Specify:		

3028 (Rev March 2017)

If sedation is required for claustrophobia, please arrange this with your patient. Mackenzie Health MRI will not dispense sedation. If there is a possibility or history of metal being in your patient's eyes, please arrange for orbit xrays 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.

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Patient Name: _____

Date of Birth: _____ (dd/mm/yyyy)

MRI Requisition

RENAL RISK FACTORS

If **YES** to any of the below, we require a current creatinine/eGFR (in the last 6 months) attached to the requisition.
The patient has **NONE** of the below risk factors ☐

☐ Hx of Renal Disease ☐ Diabetes ☐ Vascular Disease ☐ Hypertension ☐ Gout

☐ On Dialysis ☐ Chemotherapy ☐ Stroke ☐ Over 70 yrs of age ☐ Cirrhosis

Date of Bloodwork: _____ (dd/mm/yyyy) Creatinine _____umol/L eGFR _____ mL/min/1.73m^2

The following items may interfere with MR imaging or be hazardous to your patient's safety. Please indicate all of the following that apply to this patient.

	YES	NO
Pacemaker * **Some pacemakers and implanted defibrillators are MRI conditional and can be scanned at Southlake Regional Health Centre.**		
If your patient has one of these devices implanted, please send this requisition with a copy of the device card and report of the most recent chest x-ray as well as the name of the hospital where the device was implanted to Southlake (Fax 905-830-5966).		
Pacemaker wires not attached to current pacemaker * **Non-grounded intravenous pacing wires are an absolute contraindication to MRI. Consider alternate exam.**		
Cerebral aneurysm clip * **Patients with cerebral aneurysm clips are not scanned at Mackenzie Health. They should be referred to the hospital where the clip was placed.**		
Cochlear implant * **Cochlear implant is an absolute contraindication to MRI. Consider alternate exam.**		
Neuro or bio stimulator device. Specify location and provide model:		
Swan Ganz line (or metallic wire tipped catheter)		
Implanted insulin/chemotherapy pump (patient must be able to remove prior to scan)		
Surgically implanted metal in ear (e.g. stapes prosthesis). Specify model:		
Orbital/eye prosthesis. Specify model if not removable:		
Has the patient ever had open heart surgery?		
Metallic aortic stents (e.g. Zenith) or transarterially placed mechanical aortic valves (e.g. TAVR/Edwards). Specify make/model:		
Any other vascular stent? Specify location:		
Artificial joint or metal rod, plate, screw or wire on any bone. Specify location:		
Other metallic or partly metallic implant (e.g. tissue expander, IUD, tubal ligation clip), endoscopy capsule or magnetic dental implant? Specify:		
Endoscopy with biopsy and clip placement within the past 2 weeks or any surgery or stent placement within the past 6 weeks? Specify:		
Any history of previous metal fragments in the eyes? Patient requires orbit xray prior to scheduling.		
Patient currently works with metal (e.g. grinder/welder). Patient requires orbit x-ray the day of MRI. Send requisition with patient.		
Shrapnel (gunfire or bomb) fragments in body? Specify location in body and date of injury:		
Is patient pregnant? If yes, EDC:		
Does patient have allergy to MRI contrast media? Specify reaction:		
Is the patient claustrophic? (please arrange for sedation)		
Does your patient have special needs that may impact ability to cooperate with scanning instructions (such as not fluent in English (patient MUST bring an interpreter), cannot hear without hearing aid, cannot transfer from wheel chair to bed alone)? Specify:		