

MRI Requisition

Telephone: 905-883-2004 **Fax:** 905-883-2043

 Other Insurance / WSIB # _____

MRN: _____

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

Patient Name: (Print Last, First)			
Address:			
Health Card Number:	Version Number:	Date of Birth:	(dd/mm/yyyy)
Primary Number: ()	<input type="checkbox"/> Cell	<input type="checkbox"/> Home	<input type="checkbox"/> Work ()
Secondary Phone Number: ()	<input type="checkbox"/> Cell	<input type="checkbox"/> Home	<input type="checkbox"/> Work ()
Clinical History and Diagnostic Questions: <input type="checkbox"/> Cancer diagnosis or staging?			
Specified exam date request? _____ (dd/mm/yyyy)			

EXAM REQUIRED (check all that apply)

Brain	Angiogram (with Gadolinium)	Musculoskeletal (Upper Extremity)
<input type="checkbox"/> Brain Routine	<input type="checkbox"/> Subclavians (Bilateral)	Shoulder <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Brain MS	<input type="checkbox"/> Renal/Mesenteric	Elbow <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Seizure	<input type="checkbox"/> Thoracic Outlet	Hand/Wrist (Inflam. Arthritis) <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Brain & MRA Cow	<input type="checkbox"/> Peripheral Runoff	Wrist <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> IAC	<input type="checkbox"/> Thoracic Aorta <input type="checkbox"/> Abdominal Aorta	Thumb/Finger – Specify:
<input type="checkbox"/> MRV Head	<input type="checkbox"/> Carotid/Vertebrals <input type="checkbox"/> Dissection	
<input type="checkbox"/> Orbits		Musculoskeletal (Lower Extremity)
<input type="checkbox"/> Sella/Pituitary	Head and Neck	Hip <input type="checkbox"/> R <input type="checkbox"/> L
	Brachial Plexus <input type="checkbox"/> Right <input type="checkbox"/> Left	Pelvis (Body) <input type="checkbox"/> R <input type="checkbox"/> L
Spine	<input type="checkbox"/> Neck (soft tissue)	Hamstring (Proximal) <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Cervical	<input type="checkbox"/> Parathyroids	Knee <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Thoracic	<input type="checkbox"/> TMJs	Ankle/Hindfoot <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Lumbar (T11-S2)	<input type="checkbox"/> Parotids	Achilles Only <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Sacrum/Coccyx (bone)		Forefoot (Osteomyelitis) <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Lumbosacral Plexus (nerves)	Chest and Breast	Hindfoot (Osteomyelitis) <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Sacroiliac Joints (sacroiliitis)	Breast <input type="checkbox"/> Mass/Follow-up	Forefoot (Inflammatory) <input type="checkbox"/> R <input type="checkbox"/> L
Whole Spine <input type="checkbox"/> Cord Compression	<input type="checkbox"/> Implant	Forefoot Other (e.g. Morton's) <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Metastases	Chest Mass <input type="checkbox"/>	
	Pelvis	Palpable Lump Work Up (With Markers)
	<input type="checkbox"/> Pelvis	Upper Extremity <input type="checkbox"/> R <input type="checkbox"/> L
Abdomen	<input type="checkbox"/> Rectal Mass	Specify:
<input type="checkbox"/> Liver	<input type="checkbox"/> Anal Fistula	Lower Extremity <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> MRCP	<input type="checkbox"/> Testicular Mass	Specify:
<input type="checkbox"/> Pancreas & MRCP	<input type="checkbox"/> Urethra (Female or Posterior Male)	Body/Other <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Spleen		Specify:
<input type="checkbox"/> Adrenals		
<input type="checkbox"/> Kidneys	Other Request	
<input type="checkbox"/> PCKD (renal size only)	Specify:	



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(Rev. March 15, 2022)

If sedation is required for claustrophobia, please arrange this with your patient. Mackenzie Health MRI will not dispense sedation. If there is a possibility of 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.

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

MRI Requisition

RENAL FUNCTION

No hx of renal disease Hx of renal disease and not on dialysis (attach eGFR within last 6 months)

Peritoneal dialysis Hemodialysis (provide schedule, e.g. MWF 14:00) _____

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 * Patients with most pacemakers and implanted defibrillators can be scanned but this must be done at the institution that implanted the device.		
Pacemaker wires not attached to current pacemaker * Non-grounded intravenous pacing wires are an absolute contraindication to MRI. Consider alternate exam.		
Cochlear implant * Patients with some cochlear implants can be scanned, at the institution that implanted the device.		
Cerebral aneurysm clip/coil *Patients with cerebral aneurysm clips/coils will only be scanned if they have been scanned since implantation at the institution that implanted the clips/coils.		
Implanted insulin/chemotherapy pump (patient must be able to remove prior to scan)		
Freestyle Libre device or similar: Indicate date of next device change _____(dd/mm/yyyy)		
Neuro or bio stimulator device or programmable ventricular shunt. Specify location and provide model:		
Swan Ganz line (or metallic wire tipped catheter)		
Surgically implanted metal in ear (e.g. stapes prosthesis). Specify model:		
Orbital/eye prosthesis. Specify model if not removable:		
Metallic aortic or iliac stents (e.g. Zenith). 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 with magnetic port, penile implant), 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:		
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 wheelchair to bed alone? Specify:		