

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: () _____ Cell Home Work () _____

Secondary Phone Number: () _____ Cell Home Work () _____

Clinical History and Diagnostic Questions: Cancer screening, 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
	<input type="checkbox"/> Neck (soft tissue)	Hamstring (Proximal) <input type="checkbox"/> R <input type="checkbox"/> L
Spine	<input type="checkbox"/> Parathyroids	Knee <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Cervical	<input type="checkbox"/> TMJs	Ankle/Hindfoot <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Thoracic	<input type="checkbox"/> Parotids	Achilles Only <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Lumbar (T11-S2)		Forefoot (Osteomyelitis) <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Sacrum/Coccyx (bone)		Hindfoot (Osteomyelitis) <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Lumbosacral Plexus (nerves)	Chest and Breast	Forefoot (Inflammatory) <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Sacroiliac Joints (sacroiliitis)	Breast <input type="checkbox"/> Mass/Follow-up	Forefoot Other (e.g. Morton's) <input type="checkbox"/> R <input type="checkbox"/> L
Whole Spine	<input type="checkbox"/> Implant	
<input type="checkbox"/> Cord Compression	Chest Mass <input type="checkbox"/>	
<input type="checkbox"/> Metastases	Cardiac	Palpable Lump Work Up (With Markers)
	*Require ECHO report and cardiology consult note.	Upper Extremity <input type="checkbox"/> R <input type="checkbox"/> L
Abdomen	Pelvis	
<input type="checkbox"/> Liver	<input type="checkbox"/> Pelvis	Lower Extremity <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> MRCP	<input type="checkbox"/> Rectal Mass	Specify: _____
<input type="checkbox"/> Pancreas & MRCP	<input type="checkbox"/> Anal Fistula	Body/Other <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Spleen	<input type="checkbox"/> Testicular Mass	Specify: _____
<input type="checkbox"/> Adrenals	<input type="checkbox"/> Urethra (Female or Posterior Male)	
<input type="checkbox"/> Kidneys	Other Request	
<input type="checkbox"/> PCKD (renal size only)	Specify: _____	



3028

(Rev. Aug 13, 2024)

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 safely. Please submit make and model of implant for review.		
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:		
Do you have any large vessel STENTS (i.e. AORTA)?		
Other metallic or partly metallic implant (e.g. tissue expander with magnetic port, penile implant), endoscopy capsule or magnetic dental implant? Specify:		
Endoscopy (Gastroscopy or colonoscopy) with biopsy AND clip placement within the past 2 months or any surgery (including laparoscopy) within the past 6 weeks. Send OR note.		
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:		