

Name: _____
 Male Female
 MRN : _____
 DOB: _____
 Address: _____

 Telephone: _____
 OHIP #: _____

MAGNETIC RESONANCE IMAGING (MRI)

St. Joseph's Health Centre
 Diagnostic Imaging Department
 30 The Queensway, Toronto ON

Bookings Only: 416-530-6169
 General Calls: 416-530-6001
 Fax Line: 416-530-6060

INCOMPLETE FORMS WILL BE RETURNED AND NOT BE PROCESSED

Area to be Scanned (be specific): _____

STUDY PRIORITY: STAT/TODAY (Call MRI Radiologist) URGENT ROUTINE **WSIB/Third Party Claim Number:** _____

CURRENT PATIENT LOCATION: EMERGENCY Inpatient Clinic/ACC Outpatient

CLINICAL HISTORY Isolation Precautions: N/A Contact Droplet Airborne Reverse

MANDATORY INFORMATION (MUST BE COMPLETED PRIOR TO SUBMISSION)

Please indicate if any of the following apply to the patient. If yes to any of the questions, we will require a current creatinine level (within 6 months of the appointment date).

Estimated Glomerular Filtration Rate (eGFR ml/min): _____

Creatinine (umol/L): _____

Date Bloodwork Completed: _____

IF THE eGFR IS UNKNOWN, COMPLETE THE BELOW INFORMATION:

- 60 years of age or older YES NO
- History of Diabetes YES NO
- History of renal disease including
 - *On Dialysis YES NO
 - *Any surgery to the Kidney YES NO
 - *Solitary Kidney YES NO
 - *Kidney Transplant YES NO
 - *History of known kidney Cancer YES NO
- Hypertension requiring medication YES NO
- Multiple Myeloma YES NO
- Previous allergic reaction to a MRI contrast agent YES NO

- Does the patient consent to appointment information being disclosed in a telephone message? YES NO
- Is patient able to come on short notice? YES NO
- Lift Device Required? YES NO
- Interpreter Required? YES NO

Language: _____

Referring Physician: If patient requires X-ray to rule out metallic foreign bodies, do you give permission for the X-rays? YES NO

PATIENT SCREENING

- Cardiac Pacemaker or pacing wires YES NO
- Aneurysm Clip YES NO
- Heart Valve Replacement YES NO
- Neurostimulator or residual wires YES NO
- Cochlear Implant YES NO
- Intrauterine Device YES NO
- Hearing Aid YES NO
- Medication Patches YES NO
- Shrapnel or Bullets YES NO
- Surgical Rods or Staples YES NO
- Dentures/Retainers YES NO
- Prosthesis (limb, joint, eye, ear) YES NO
- Body Piercing/Jewellery YES NO
- Other Implanted Devices: YES NO
- Have you EVER cut, welded or ground metal? YES NO
- Have you EVER had metal in your eye? YES NO
- Is there a chance that you might be pregnant? YES NO
- Are you claustrophobic? YES NO

Previous Surgery

- Head: Brain YES NO
- Eye YES NO
- Ear YES NO
- Chest/Heart YES NO
- Spine YES NO
- Abdomen YES NO
- Other: YES NO

Please Specify Type and Date below

Height: _____ **Weight:** _____

REQUESTING PHYSICIAN

Physician Name: _____

Telephone Number: _____

Physician Specialty: _____

Pager Number: _____

Address: _____

Fax: _____

Copies to: _____

DATE/TIME

DD / Month / YYYY ____ : ____ h