ST JOSEPH'S HEALTH CENTRE TORONTO

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			**Please Specify Type and Date below**
Head: Brain	☐ YES	☐ NO	
Eye	☐ YES	☐ NO	
Ear	☐ YES	☐ NO	
Chest/Heart	☐ YES	☐ NO	
Spine	☐ YES	☐ NO	
Abdomen	☐ YES	☐ NO	
Other:	☐ YES	☐ NO	

Height:_____ **Weight:**_____

REQUESTING PHYSICIAN

Physician Name: _____ Telephone Number: _____

Physician Specialty: _____ Pager Number: _____

Address: _____ Fax: _____

_____ Copies to: _____

DATE/TIME	**Physician Signature**	**Physician's Name (Please Print)**
DD / Month / YYYY __ __:__ __h		