Print name:

MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

OUTPATIENT MRI REQUISITION FORM

Download link: ***www.tehn.ca/imaging***

MRI Fax: 416-469-6241 MRI Tel.: 416-469-6838

Requisition date		Requested exam date	

Area to be examined (please be specific):

Clinical Information/Working Diagnosis:

Other Tests and Results to date (attach any relevant reports):

MRI:

CT:

Ultrasound:

MRI PATIENT SCREENING
(to be filled out by Referring Physician)

#	Question	Yes	No
1	Does the patient have a history of an eye injury from a **metallic** object or chips? ***Referring Physicians: If the answer is YES, please order an X-RAY of the Orbits on the patient prior to the MRI**	☐	☐
2	Could the patient be pregnant?	☐	☐
3	Does the patient have any of the following? **Cardiac Pacemaker/Leads** ☐ ☐ **Artificial Cardiac Valve/ Stents** ☐ ☐ **Aneurysm Clips** ☐ ☐ **Cochlear Implants** ☐ ☐ **Any other implanted device** ☐ ☐ **If yes, specify type of stent or other devices (fax reports):** _____ _____		
4	Did the patient ever have any surgery? **If yes, please specify type and date:** _____	☐	☐
5	Is the patient claustrophobic? ***If yes, medication must be ordered by physician prior to exam**	☐	☐
6	Patient's current weight? _____ **(Maximum allowable table weight 350 lbs/159 kg)**	☐ Kg	☐ Lb
7	Do you know of any precautions for a MRI exam on this patient? If yes, please specify: _____ _____	☐	☐

Please attach a Patient Sticker or fill in Patient Information below:

Patient MRN (if known): _____

Patient Last Name: _____

Patient First Name: _____

Health Card #: _____ Version: _____

Address: _____

Postal Code: _____ D.O.B.: _____

Home Phone: _____

Cell Phone (optional): _____

Email (optional): _____

Patient would like to receive **Exam Reminders** via
☐ Text Messages or ☐ Emails

Question	Yes	No
Is this a follow-up MRI?	☐	☐
Does the patient use a **wheelchair** or a **walker**?	☐	☐
Does the patient require sedation? **(If yes, Referring Physician to arrange)**	☐	☐
Can the patient come on a short notice?	☐	☐

☐ WSIB case. Claim #: _____ ☐ Other non-OHIP case

(For DI office use)
WSIB Adjudicator: _____
Approval date: _____

FOR MRI TEAM USE ONLY

Radiologist: _____ Priority Rating: 1 2 3 4

Protocol Routine:

Gadolinium: Yes eGFR No

Referring Physician	Name:
Fax:	
Address and postal code:	
Phone:	
Signature:	

"I expect that the Radiologist will order additional exams on my behalf, related to the current investigation, if necessary."

☐ **Creatinine required within 90 days of appointment date**

[DI Use Only] Booking date:

Email for non-confidential correspondence: **imaging@tehn.ca.**
Form # SP932. Forms WG Approval Date: Feb 7, 2018. Rev. 3/27/18