



**MICHAEL
GARRON
HOSPITAL**

TORONTO EAST HEALTH NETWORK

**OUTPATIENT MRI
REQUISITION FORM**

Download link: www.tehn.ca/imaging

Requisition date		Requested exam date	
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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? <i>*Referring Physicians: If the answer is YES, please order an X-RAY of the Orbits on the patient prior to the MRI</i>	<input type="checkbox"/>	<input type="checkbox"/>
2	Could the patient be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
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): _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4	Did the patient ever have any surgery? If yes, please specify type and date: _____	<input type="checkbox"/>	<input type="checkbox"/>
5	Is the patient claustrophobic? <i>*If yes, medication must be ordered by physician prior to exam</i>	<input type="checkbox"/>	<input type="checkbox"/>
6	Patient's current weight? _____ (Maximum allowable table weight 350 lbs/159 kg)	<input type="checkbox"/> Kg	<input type="checkbox"/> Lb
7	Do you know of any precautions for a MRI exam on this patient? If yes, please specify: _____	<input type="checkbox"/>	<input type="checkbox"/>

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

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?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient use a wheelchair or a walker ?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient require sedation? (If yes, Referring Physician to arrange)	<input type="checkbox"/>	<input type="checkbox"/>
Can the patient come on a short notice?	<input type="checkbox"/>	<input type="checkbox"/>

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

WSIB Adjudicator: _____ (For DI office use)

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: _____