

Please Note: This form is to be used for outpatient requests only. Please ensure all fields are completed and attach MRI screening forms (when applicable) to avoid delays in patient processing.

PATIENT INFORMATION

LAST NAME		FIRST NAME		MIDDLE INITIAL
ADDRESS		CITY	PROVINCE	POSTAL CODE
CELL PHONE	ALTERNATIVE PHONE		EMAIL	
Patient consents to appointment information being disclosed to them via text or e-mail <input type="checkbox"/> Yes, text <input type="checkbox"/> Yes, e-mail				
BIRTH SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	GENDER IDENTITY <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other:		DOB (YYYY/MM/DD)	HEIGHT (CM)
WEIGHT (KG)		HEALTH CARD NUMBER	VERSION CODE:	WSIB CLAIM NO.
OTHER (self-pay, research, 3 rd party payer)		<input type="checkbox"/> INTERPRETER REQUIRED Preferred Language:		
MOBILITY REQUIREMENTS				

EXAM INFORMATION AND HISTORY

TEST/REGION TO BE EXAMINED (Choosing Wisely checklist MUST accompany referrals where appropriate i.e. knee)
REASON FOR EXAM/CLINICAL HISTORY

SCREENING & PRECAUTIONS (Please answer all of the following questions)

NEPHROPATHY Impaired renal function? <input type="checkbox"/> Yes <input type="checkbox"/> No On dialysis: <input type="checkbox"/> Yes <input type="checkbox"/> No If the answer to any of the above question(s) is yes, please provide eGFR or Creatinine results within 6 months: eGFR (ml/min/1.73 ²) _____ DATE (YYYY/MM/DD) _____ Creatinine _____ DATE (YYYY/MM/DD) _____	POSSIBLE MRI CONTRAINDICATIONS: <input type="checkbox"/> Cardiac pacemaker or defibrillator <input type="checkbox"/> Prior metal fragment <input type="checkbox"/> Eye surgery/injury (excl. lens implants, cataract, or laser surgery) <input type="checkbox"/> Ear surgery/implant (excl. ear tubes) <input type="checkbox"/> Implanted stimulators or electrodes <input type="checkbox"/> Any filters, stents, coils, grafts, valves, or programmable shunts <input type="checkbox"/> Aneurysm surgery <input type="checkbox"/> Weight is above limit (Max WT: 250kg/551lbs) <input type="checkbox"/> None of the above Please provide operative report and specify the device information below (include as much detail as possible): MAKE: _____ MODEL NO. _____ INSTITUTION WHERE TREATMENT WAS RECEIVED: _____ DATE (YYYY/MM/DD): _____
Is the patient claustrophobic? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the patient require oral sedative prescribed by requesting physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Known allergy to MRI contrast agent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Chance of Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

REFERRING PROVIDER

NAME	BILLING NO.	LICENSE NO.	
ADDRESS	CITY	PROVINCE	POSTAL CODE
PRIMARY PHONE	URGENT FINDINGS PHONE	COPY TO	
PROVIDER SIGNATURE			DATE
OFFICE USE ONLY			
PRIORITY <input type="checkbox"/> P1 <input type="checkbox"/> P2 <input type="checkbox"/> P3 <input type="checkbox"/> P4	TIMED: <input type="checkbox"/> Yes <input type="checkbox"/> No	SPECIFIED DATE:	
CCO: <input type="checkbox"/> Yes <input type="checkbox"/> No	PROTOCOL:	RADIOLOGIST:	