HOSPITAL ID: _____

Ontario Health West

OUTPATIENT MRI REQUISITION FORM

PATIENT INFORMATION

SURNAME	FIRST NAME	MIDDLE INITIAL

ADDRESS	CITY	PROVINCE	POSTAL CODE

MOBILE PHONE #	ALTERNATE PHONE #	EMAIL

Patient consents to appointment information being disclosed to them via text or e-mail ☐ Yes, text ☐ Yes, e-mail

SEX ASSIGNED AT BIRTH	GENDER IDENTITY	DOB (YYYY/MM/DD)	HEIGHT (CM)	WEIGHT (KG)
☐ Female ☐ Male	☐ Female ☐ Male ☐ Other			

HEALTH CARD NUMBER (HN)	VERSION CODE (VC)	WSIB CLAIM #	OTHER (Self-pay, research, 3rd party payor)

☐ **INTERPRETER REQUIRED**
Preferred language

ACCESSIBILITY CONCERNS OR REQUIREMENTS

ALTERNATE CONTACT (IF NOT PATIENT)	CONTACT NAME	CONTACT PHONE #

EXAM INFORMATION AND HISTORY

TEST / REGION TO BE EXAMINED (Choosing Wisely checklists MUST accompany referrals where appropriate)

☐ **TIMED FOLLOW UP** **DATE REQUESTED** (YYYY/MM/DD)

MRI availability is limited; requested dates will be accommodated where possible.

REASON FOR EXAM / CLINICAL HISTORY (Please also include presenting symptom(s), relevant underlying diagnosis and therapies, where applicable)

SCREENING & PRECAUTIONS

RENAL ASSESSMENT

Impaired renal function? ☐ Yes ☐ No

On dialysis ☐ Yes ☐ No

If the answer to any of the above question(s) is yes, then please provide the most recent eGFR results (within the past 3–6 months)

eGFR RESULT (ml/min/1.73^2) **DATE COLLECTED** (YYYY/MM/DD)

☐ Known hypersensitivity to contrast agents
☐ Currently pregnant
☐ Currently breastfeeding
☐ Patient cannot provide reliable medical history or provide consent to contrast injections where applicable
☐ Requires general anesthesia
Rationale

For patients with claustrophobia requiring oral sedation, the referring provider is responsible for prescribing the medications. Patients taking oral sedation must not drive and should arrange alternative transportation.

POSSIBLE MRI CONTRAINDICATIONS

☐ Has metal fragments in eye(s)/body
☐ Cardiac pacemaker or defibrillator
☐ Eye surgery/injury (excl. lens implants, cataract, or laser surgery)
☐ Ear surgery/implant
☐ Implanted stimulators or electrodes
☐ Any filters, stents, coils, grafts, valves or programmable shunts
☐ Aneurysm surgery/clips
☐ Surgery within the last six (6) weeks
☐ 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

REFERRING PROVIDER

PROVIDER NAME	BILLING #	PROFESSIONAL ID

ADDRESS	CITY	PROVINCE	POSTAL CODE

PHONE #	FAX #	COPY TO

PROVIDER SIGNATURE	DATE

OFFICE USE ONLY

PRIORITY ☐ P1 ☐ P2 ☐ P3 ☐ P4	TIMED ☐ Yes ☐ No	SPECIFIED DATE

CCO ☐ Cancer ☐ No	PROTOCOL	RADIOLOGIST