Ontario
South West Local Health Integration Network

Choosing Wisely Canada

MRI REQUISITION

(Check one site)

☐ Grey Bruce Health Services – Owen Sound F: 519-376-3952
☐ Huron Perth Healthcare Alliance – Stratford F: 519-272-8247
☐ London Health Sciences Centre - UH F: 519-663-3544
☐ London Health Sciences Centre – Vic/Children's F: 519-667-6826
☐ St. Joseph's Health Care London F: 519-646-6025
☐ Woodstock Hospital F: 519-421-4238

PATIENT INFORMATION:

Surname: ____________________ First Name: ____________________ Middle Initial: ________
Gender: ☐ M ☐ F ☐ X Date of Birth (YYYY-MM-DD): ____________
Street Address: ______________ Apt: ________ City: ____________ Province: ________ Postal Code: ________
Health Card No. : ______________ Version Code: ________ Research or 3rd Party No.: ______________

Telephone (Day): ______________ (Evening): ______________ (Cell): ______________
☐ Outpatient ☐ Long Term Care ☐ Inpatient ☐ ED
WSIB: ☐ Y ☐ N ________ WSIB No.: ______________ Date of Injury (YYYY-MM-DD): ____________
Mobility: ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Mechanical Lift Preferred Language: ☐ EN ☐ OTHER

Y N Please check the following:
☐ ☐ Breast feeding
☐ ☐ History of cancer
☐ ☐ Medication patch (Foil)
☐ ☐ Piercings (Remove prior to exam)
☐ ☐ Pregnant _______ wks.
☐ ☐ Shrapnel or bullets
☐ ☐ Surgery in last 6 wks.
☐ ☐ Tattoos

Precautions:
☐ TB ☐ MRSA ☐ Shingles
☐ VRE

Y N Contrast Risk Factors
☐ ☐ Diabetic
☐ ☐ Hypertension
☐ ☐ Impaired renal function
☐ ☐ MRI contrast reaction
☐ ☐ On dialysis
☐ ☐ Gout
☐ ☐ Protein in Urine
☐ ☐ Kidney Surgery

If one or more of the above is Y provide serum creatinine result within last 6 months:

____
YYYY-MM-DD

Y N Possible MRI Contraindications
☐ ☐ History of Metal in Eye (*X-ray may be required)*
☐ ☐ Aneurysm surgery*
☐ ☐ **Cardiac pacemaker or defibrillator***
☐ ☐ Cochlear or Ocular Implants*
☐ ☐ Coils, filters, grafts, stents *
☐ ☐ Electronic devices, implanted or not implanted*
☐ ☐ Heart valve*
☐ ☐ Implanted stimulators, electrodes or pumps*
☐ ☐ Shunts: ☐ Programmable* ☐ Non-Programmable*
☐ ☐ Other: ______________

*Please forward surgical report and specify the:

Make/Model: ______________ Date: ______________

Institution of surgery: ______________

☐ Y ☐ N Surgery in exam area ☐ Y ☐ N Timed ☐ Y ☐ N Relevant reports attached HEIGHT ________ CM/FT WEIGHT ________KG/LBS

REFERRING PHYSICIAN:

Last Name: ______________ First Name: ______________ **Signature:** ______________
Address: ______________ City: ______________ Province: ________ Postal Code: ________
Telephone: ______________ Fax: ______________ Billing No.: ______________

COPY TO:

EXAMINATION REQUESTED: ______________ **Working Diagnosis:** ______________
Clinical Information: ☐ Y ☐ N Recent trauma

Considerations: ☐ Claustrophobia ☐ Mild Sedation (not provided) ☐ General Anaesthesia ☐ Paediatric ☐ Interpreter Required

OFFICE USE ONLY

Protocol:

☐ P1 ☐ P2 ☐ P3 ☐ P4 ☐ Timed ☐ Contrast

X-rays required: ☐ Y ☐ N Staff Initials: ____________

Appointment Date and Time: ______________

NOTE: This requisition may be booked at an alternate site in the South West LHIN to improve patient access.