



MRI REQUISITION

Fax all MRI requests to 905-815-5103

**Incomplete / illegible requisitions will be returned
 resulting in delay to booking the appointment**

Physician's Name: _____

Address: _____

Postal Code: _____

Phone: _____ Fax: _____

Copies to: _____

Date: _____

1. REGION OF INTEREST: _____

**2. CLINICAL HISTORY; DIFFERENTIAL DIAGNOSIS;
 SPECIFIC QUESTIONS?**

**In general, MRI is of no value in the management of osteoarthritis (OA).
 Referral to the Hip & Knee Rapid Access Clinic should be considered.
www.mhcentralintake.com**

3. RELEVANT PRIOR IMAGING STUDIES?
 Halton Healthcare External

Requisition must include external reports or booking will be delayed.
MSK studies (excluding the spine) require X-rays within 6 months.


**For follow-up of or for comparison to previous outside studies, the
 patient must bring the outside IMAGES to appointment or a delay in
 interpretation may result while we attempt to obtain the images.**

4. FOR STUDIES WHICH MAY REQUIRE IV CONTRAST:
 (generally breast, abdomen, pelvis, prostate, non-brain MRA)

- a) Previous reaction to MRI contrast / Gadolinium Yes No
 If yes: a contrast risk form will be forwarded for specifics
- b) If known renal dysfunction, is eGFR < 30? Yes No
- c) Dialysis patients: Hemodialysis Peritoneal Dialysis
- d) Acute Kidney Injury? Yes No

Physician Signature: _____

Nephrogenic Systemic Fibrosis (NSF)



Even in patients with acute kidney injury (AKI), chronic kidney disease with eGFR < 30 mL/min/1.73m², or on dialysis, the newer macrocyclic type contrast agents (GBCA) used by our facility can be administered with exceedingly low risk when enhanced MRI is considered necessary and no alternative test is available. Given this risk profile, the CAR no longer recommends screening for renal dysfunction. For hemodialysis patients, post procedure dialysis is still recommended, and for peritoneal dialysis, alterations in PD prescription might be considered on a per patient basis.

Name: _____ M / F / X

Address: _____

Phone (H) _____ (Cell) _____

Do we have your consent to leave information pertaining to your appointment?
 Yes - Indicate phone # _____

D.O.B. _____ Health Card #: _____

Unit #: _____

OPTION – Appointment will be scheduled at one of the following sites based on earliest available appointment Milton District Hospital or Oakville Trafalgar Memorial Hospital

WSIB / Third Party Yes No **Claim #:** _____

Patient Safety Screening Questions

All questions must be answered or request will be returned

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. History of orbital injury by metal requiring medical attention?
If metal not clearly removed – obtain orbital radiographs. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is the patient claustrophobic?
If "Yes", consider prescription for PRN medication (we do not provide). If Rx provided, patient must be accompanied. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are there other potential difficulties? Describe _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Pregnancy status: If "Yes" or unclear at the time of exam, the study may be deferred. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any of the following: | | |
| • Cardiac Pacemaker..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • Artificial Cardiac Valve..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • Retained Pacing Wires..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • Brain Aneurysm Clips..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • Neurostimulator | <input type="checkbox"/> | <input type="checkbox"/> |
| • Cochlear (ear) Implants..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • Shrapnel / Bullets..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • Metal rods, plates, screws, wires..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • List any Implanted Devices: _____ | | |
| 6. Type and date of ALL surgeries and any implanted devices from procedures: | | |
| _____ | | |
| _____ | | |
| 7. Patient's WEIGHT: _____ lbs. (Maximum of 550 lbs.) | | |
| 8. Is an interpreter required? <input type="checkbox"/> Yes
Sign Language Interpreter? <input type="checkbox"/> Yes | | |
| NOTE: If the patient is unable to speak English, he/she must be accompanied by a translator or interpreter for the whole duration of the MRI appointment for safety reasons. | | |
| 9. Does patient require: <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Hoyer Lift <input type="checkbox"/> Special needs* | | |
| * Please describe: _____ | | |

7. Patient's WEIGHT: _____ lbs. (Maximum of 550 lbs.)

8. Is an interpreter required? Yes
 Sign Language Interpreter? Yes

NOTE: If the patient is unable to speak English, he/she must be accompanied by a translator or interpreter for the whole duration of the MRI appointment for safety reasons.

9. Does patient require: Wheelchair Walker Hoyer Lift Special needs*
 * Please describe: _____

Patient / Substitute Decision Maker (SDM) Signature:

SDM Contact # _____

MRI APPOINTMENT DATE: _____

Time: _____ **Site:** OAKVILLE MILTON