

## MRI REQUISITION – this form can be found on [www.swpca.ca](http://www.swpca.ca) **Check one Site:**

- |   |                 |  |                 |
|---|-----------------|--|-----------------|
| <input type="checkbox"/> Grey Bruce Health Services - Owen Sound      | F: 519-376-3952 | <input type="checkbox"/> LHSC - VH /Children's           | F: 519-667-6826 |
| <input type="checkbox"/> Huron Perth Health Care Alliance - Stratford | F: 519-272-8247 | <input type="checkbox"/> St. Joseph's Health Care London | F: 519-646-6025 |
| <input type="checkbox"/> LHSC - UH                                    | F: 519-663-3544 | <input type="checkbox"/> 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 3<sup>rd</sup> 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
- VRE  Shingles

### 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: \_\_\_\_\_

- Prep: NPO 4 hours prior to arrival
- No prep

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