Halton Healthcare
GEORGETOWN • MILTON • OAKVILLE

Diagnostic Imaging Department

MRI REQUISITION

Mailing Address: OTMH, 3001 Hospital Gate, Oakville, ON, L6M 0L8
Telephone: 905-338-4601 Fax: 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: _____

1. REGION OF INTEREST: _____

_____

2. CLINICAL HISTORY; DDx; SPECIFIC QUESTION?

_____

_____

_____

3. RELEVANT NON HHS IMAGING STUDIES? Yes ☐ No ☐
If yes, reports must accompany requisition or booking will be delayed.
N.B. MSK studies, (not incl. spines), require radiographs within 6 months

4. FOR STUDIES WHICH MAY REQUIRE IV CONTRAST:
(generally breast, abdomen, pelvis, and nonbrain MRA)
Any renal abnormality / dysfunction, dialysis, hypertension, gout or diabetes? Yes ☐ No ☐

If yes - provide specifics + eGFR. If **< 60** specify if **stable or unstable**

_____

Most recent eGFR value: _____ Date: _____

IF < 60, a repeat eGFR is required. NOTE: acute renal failure is a relative contraindication
- within 4 weeks of study date if renal function is STABLE
- within 48 hours of study if INPATIENT or unstable renal function

RESULTS: Fax to MRI @ 905-815-5103 / or patient bring to APPT.

5. *Physician Signature:* _____

Nephrogenic Systemic Fibrosis (NSF)

IV CONTRAST is relatively contraindicated in patients with acute renal failure, chronic renal failure with eGFR < 30; dialysis, especially peritoneal dialysis.
Suggest consultation with Radiologist regarding other potential imaging strategies.

Because of potential delayed onset of NSF, if contrast is still medically necessary in above patients, the **referring physician** must obtain consent.

Physician: CONSENT obtained for NSF risk: ☐ **Yes**

Physician Signature: _____

Date Requisition Received: _____

Name: _____ M / F

Address: _____

_____

Phone (H): _____ (Cell): _____

(Work): _____

Do we have your consent to leave information pertaining to your appointment?
☐ **No** ☐ **Yes** - If **YES** - Indicate phone # : _____

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

Unit #: _____

OPTION - Refer to Alternative Organization if Wait List Shorter: Yes ☐ No ☐
☐ Trillium Health Centre ☐ Credit Valley Hospital ☐ Either

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

Patient Safety Screening Questions

All must be answered. For any "Yes", please clarify in #5

	YES	NO
1. History of orbital injury by metal requiring medical attention? If metal not clearly removed - obtain orbital radiographs.	☐	☐
2. Is the patient claustrophobic? If "Yes", consider prescription for PRN medication (we do not provide). Are there other potential difficulties?	☐	☐
3. Pregnancy status: If "Yes" or unclear at the time of exam, the study may be deferred.	☐	☐
4. Do you have any of the following:		
• Cardiac Pacemaker	☐	☐
• Artificial Cardiac Valve	☐	☐
• Retained Pacing Wires	☐	☐
• Brain Aneurysm Clips	☐	☐
• Neurostimulator	☐	☐
• Cochlear Implants	☐	☐
• Shrapnel / Bullets	☐	☐
• Dentures / Braces	☐	☐
• Metal rods, plates, screws, wires	☐	☐
• Other Implanted Devices: _____		

5. Type and date of ALL surgeries (make / model of all implants required)

_____

_____

_____

6. What is your current WEIGHT: _____ lbs. (Maximum of 440 lbs.)

7. Do you require an interpreter? ☐ Yes ☐ No
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.

8. Do you require: ☐ Wheelchair ☐ Walker ☐ Hoyer Lift ☐ Special needs*
* Please describe: _____

Patient (or Substitute Decision Maker) signature:

_____

If Substitute, indicate relationship to patient _____

Phone # _____

MRI APPOINTMENT DATE:

Day: _____ **Month:** _____ **Year:** _____

Time: _____

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