Trillium HEALTH CENTRE

Diagnostic Imaging Requisition
M.R.I.

Hospital Unit #: _____ **Booking Office: Telephone** (905) 848-7554 **Fax** (905) 848-7295

IMPORTANT NOTICE: A booking will not be made for any MRI examination unless all sections of this form are completed by the Referring Physician. If the test is being requested based on abnormalities found on an Imaging study performed outside of Trillium Health Centre, the relevant mages/films/reports **MUST** accompany this requisition. The "MRI Patient Screening" section **must be completed and signed by the patient.**

Office Use Only:	**Diagnostic Imaging Protocol Use Only**
Date Requisition received: _____	
Appointment Date: _____ / _____ / _____ (DD / MM / YYYY)	
Time: _____	

IF UNABLE TO KEEP APPOINTMENT, PLEASE CALL (905) 848-7554 24 HOURS IN ADVANCE TO CANCEL

Patient Name: _____ (Surname) _____ (First Name)

Date of Birth: **Male** ☐ **Female** ☐

Accurate Weight (Max 300 lb): _____

Health Card No: _____ **Version Code:** _____

Address: _____

City: _____ **Postal Code:** _____

Telephone Res: ( ) **Bus: ( )**

Exam Requested: _____

Area of Interest: _____

Clinical Information: _____

Previous Imaging Studies (Please attach report) :

☐ X-Ray ☐ Ultrasound ☐ MRI
☐ Nuclear Medicine ☐ CT Scan ☐ Other

Referring Physician: _____

Address: _____

Phone: ( ) _____

Fax: ( )

Physician Signature:

Please send copies to:

Physician: _____

Address: _____

Physician: _____

Address:

PATIENT SCREENING

For all questions, please check either 'Yes' or 'No'		YES	NO
Note: If the answer to #1 or #2 is 'Yes', an X-Ray of the Orbits must be carried out and the report is attached			
1.	Have you ever worked as a metal grinder/Welder?	[ ]	[ ]
2.	Has metal ever gone into your eye?	[ ]	[ ]
3.	Could you be pregnant?	[ ]	[ ]
4.	Do you have any of the following?		
	- Cardiac Pacemaker	[ ]	[ ]
	- Artificial Cardiac Valve…Make & Model	[ ]	[ ]
	- Aneurysm Clips…Type/Where?	[ ]	[ ]
	- Neurostimulator	[ ]	[ ]
	- Cochlear Implants	[ ]	[ ]
	- Lens Implants…If 'Yes", when?	[ ]	[ ]
	- Shrapnel / Bullet…If 'Yes', where?	[ ]	[ ]
	- Porta-Cath…Pump?	[ ]	[ ]
	- Dentures / Braces	[ ]	[ ]
	- Any other implanted device…Specify	[ ]	[ ]
5.	Have you ever had surgery on your . . .		
	- Head	[ ]	[ ]
	- Neck	[ ]	[ ]
	- Spine	[ ]	[ ]
	- Chest	[ ]	[ ]
	- Abdomen	[ ]	[ ]
	- Arms / Legs	[ ]	[ ]
6.	Is the patient subject to claustrophobia?	[ ]	[ ]
	If 'Yes', medication is to be prescribed.		

If the answer to any of the above is 'Yes", please explain:

Patient Signature:

Technologist Signature:

INCOMPLETE AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED