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

PATIENT INFORMATION:

Surname: _____ First Name: _____ Middle Initial: _____

Gender: _____ Date of Birth (YYYY-MM-DD): _____ Height: _____ cm Weight: _____ kg

Street Address: _____ Apartment: _____ City: _____ Province: ____ Postal Code: _____

Telephone (Day): _____ (Evening): _____ (Cell): _____

☐ Outpatient ☐ Long Term Care ☐ Inpatient ☐ Isolation Precautions: _____

MRN: _____ Insurance: Province: ___ No.: _____ Research or 3rd Party No.: _____

WSIB: Y ○ N ○ WSIB No.: _____ Date of Injury (YYYY-MM-DD): _____

Mobility: ☐ Ambulatory ☐ Wheelchair ☐ Stetcher ☐ Mechanical Lift Preferred Language: ○ EN ○ FR _____ Other

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

EXAMINATION REQUESTED: _____

Working Diagnosis: _____

Clinical Information: _____

_____

_____

Y ○ N ○ Surgery in exam area

Y ○ N ○ Timed: _____ *Requested Date*

Y ○ N ○ Relevant reports attached

Y N Please check the following, if applicable

- ○ ○ Breast feeding
- ○ ○ History of cancer
- ○ ○ Medication patch (Foil)
- ○ ○ Piercings (Remove prior to exam)
- ○ ○ Pregnant _____ wks.
- ○ ○ Shrapnel or bullets
- ○ ○ Surgery in last 6 wks.
- ○ ○ Tattoos

Y N Contrast Risk Factors

- ○ ○ Diabetic
- ○ ○ Hypertension
- ○ ○ Impaired renal function
- ○ ○ MRI contrast reaction
- ○ ○ On dialysis

Contrast Patient ≥ 60 yrs.:

Recent serum creatinine result: _____

Sample date: _____ 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: _____

REFERRING PHYSICIAN:

Last Name: _____ First Name: _____ **Signature:** _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Telephone: _____ Fax: _____ Billing No.: _____

COPY TO:

Last Name: _____ First Name: _____ Fax: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

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.