SHN
SCARBOROUGH HEALTH NETWORK

# Request for MRI

☐ Outpatient ☐ Inpatient ☐ ED loc. _____

☐ **BIRCHMOUNT**
3030 Birchmount Road
Scarborough, ON M1W 3W3

☐ **CENTENARY**
2867 Ellesmere Road
Scarborough, ON M1E 4B9

☐ **GENERAL**
3050 Lawrence Ave East
Scarborough, ON M1P 2V5

**PHONE** 416-431-8167 **FAX** 416-431-8141

*Outpatient requests will be given first available at any department unless specified*

## PATIENT INFORMATION

Name _____ Date of birth _____ Sex ☐ F ☐ M ☐ Other
*Last name, First name* *Day-Month-Year*

Health card _____ Version code _____ Hospital ID _____

Address _____

City _____ Postal code _____ Phone 1 _____ Phone 2 _____
*Preferred* *Alternate*

## SCREENING

NEPHROPATHY

Hemodialysis ☐ Y ☐ N
*If yes and receiving gadolinium, dialysis must be arranged same day*

Peritoneal dialysis ☐ Y ☐ N
*If yes and receiving gadolinium, prescription may need alteration*

PRECAUTIONS - *completed with patient*

Patient weight _____ kg

Worked with metal ever (e.g. grinding, welding) ☐ Y ☐ N

Previous eye injury involving metal ☐ Y ☐ N
*If yes, orbits x-ray report must be attached*

Claustrophobia requiring sedation ☐ Y ☐ N
*If yes, referring physician to provide sedation*

Chance of pregnancy ☐ Y ☐ N

Requires mobility assistance ☐ Y ☐ N

Does patient have:

Pacemaker, defibrillator, implanted cardiac leads ☐ Y ☐ N

Cochlear (ear) implant ☐ Y ☐ N

Aneurysm clips, coils, or stents ☐ Y ☐ N

Artificial heart valve ☐ Y ☐ N

Infusion pump or neurostimulator ☐ Y ☐ N

Any other surgical implantable device/prosthesis ☐ Y ☐ N

Shrapnel/bullets ☐ Y ☐ N
*Manufacturer and model number of implantable devices required*

Any previous surgery to ears, eyes, brain, or heart ☐ Y ☐ N

Any medical procedure or surgery in last 6 weeks ☐ Y ☐ N

*Provide details of precautions (and attach relevant operative notes):*

## REGION TO BE EXAMINED

## CLINICAL INDICATION/RELEVANT HISTORY

*Relevant previous imaging reports must be attached*

INTERNAL USE

Priority ☐ 1 ☐ 2 ☐ 3 ☐ 4 | ☐ Timed

CCO ☐ Breast screen ☐ Cancer ☐ Other | ☐ Rad review

Rad _____

## BILLING

☐ OHIP ☐ WSIB claim # _____ ☐ Other _____

## REFERRING PHYSICIAN

*Name, address, fax, phone, billing number:*

*Send copies to:*

Patient Signature ✗ _____ Signature ✗ _____ Date _____

*Incomplete or unsigned requests will be returned and may result in delay*