ST. JOSEPH'S HEALTH CENTRE TORONTO

Name: ______________________
Male ☐ Female ☐
MRN : ______________________
DOB: ______________________
Address: ______________________

____
Telephone: ______________________
OHIP #: ______________________

MAGNETIC RESONANCE IMAGING (MRI)

St. Joseph's Health Centre
Diagnostic Imaging Department
30 The Queensway, Toronto ON

Bookings Only: 416-530-6169
General Calls: 416-530-6001
Fax Line: 416-530-6060

INCOMPLETE FORMS WILL BE RETURNED AND NOT PROCESSED

EXAMINATION(S) REQUESTED ☐ STAT/TODAY (Call MRI Radiologist) ☐ URGENT ☐ ROUTINE

Area to be Scanned (be specific): ______________________

Current Patient Location: ☐ Outpatient ☐ Clinic/ACC ☐ Emergency ☐ Inpatient
Study to be Done as: ☐ Outpatient ☐ Inpatient

WSIB/Third Party Claim Number: ______________________

CLINICAL HISTORY

Isolation: ☐ **N/A** ☐ **Contact** ☐ **Droplet** ☐ **Airborne** ☐ **Reverse**
Gadolinium Allergy: ☐ **NO** ☐ **YES (Contact DI for pre-meds)**

PATIENT SCREENING (MUST BE COMPLETED PRIOR TO SUBMISSION)

Referring Physician: If patient requires X-rays to rule out metallic foreign bodies, do you give permission for the X-rays ☐ YES ☐ NO

Place a check mark in the box for any of the following:

☐ Cardiac Pacemaker
☐ Heart Valve Replacement
☐ Shrapnel or Bullets
☐ Surgical Rods or Staples
☐ Dentures/Retainers
☐ Prosthesis (limb, joint, eye, ear)
☐ Body Piercing/Jewellery
☐ Aneurysm Clips
☐ Neurostimulator
☐ Intrauterine Device
☐ Hearing Aid
☐ Medication Patches
☐ Tattoos/Permanent Make-Up
☐ Other Implanted Devices

Please answer the following questions:

Question	YES	NO
Have you EVER cut, welded or ground metal?	☐ YES	☐ NO
Have you EVER had metal in your eye?	☐ YES	☐ NO
Is there a chance that you might be pregnant?	☐ YES	☐ NO
Are you claustrophobic?	☐ YES	☐ NO
Have you ever had surgery? Type: ______________	☐ YES	☐ NO
Have you had orbital X-rays?	☐ YES	☐ NO

Where/When: ______________________
Height: Weight:

CONTRAST ENHANCED STUDIES ONLY

For all patients greater than 60 years of age or those at risk for underlying renal and severe liver disease, diabetes, hypertension, solitary kidney, and/or previous organ transplant, complete the following:
Estimated Glomerular Filtration Rate (eGFR) measured in mL/min (within last 6 weeks): ______________________
If eGFR is not available, complete the following (required for eGFR calculation):
Creatinine (umol/L) ______________ (within last 6 weeks) Age: ___________ years Gender: ☐ M ☐ F ☐ Ethnicity: Black
Date Bloodwork Completed: ______________ (DD/MM/YYYY)

ADDITIONAL INFORMATION

☐ Falls Risk ☐ Lifting Device Required
☐ Patient Requires Sedation for MRI
Does Patient Consent to Appointment Information Being Disclosed in a Telephone Message? ☐ Yes ☐ No
Is Patient Able to Come in on Short Notice? ☐ Yes ☐ No

Contact Telephone Number (if different from above): ______________________

☐ Interpreter Required: Language: ______________________
Contact Name: ______________________
Telephone Number: ______________________

REQUESTING PHYSICIAN

Address: ______________________
City: ______________________
Postal Code: ______________________
Telephone Number: ______________________
Fax: ______________________

Copy to: ______________________
MD (Physician's Printed Name)

DATE/TIME	SIGNATURE	PRINT NAME
DD / Month / YYYY __ __:__ __h		