PRHC Diagnostic Imaging Services
Magnetic Resonance Imaging (MRI) Requisition

Fax: 705-876-5047

PATIENT LABEL

CLIENT/PATIENT INFORMATION		
Name:	DOB (DD/MM/YYYY):	
Health Card #:	Phone #:	
Address:	City:	Postal Code:
☐ Inpatient ☐ Outpatient ☐ Wheelchair ☐ Ambulatory ☐ Non Ambulatory		
Is this WSIB? ☐ Yes ☐ No Claim #:		

EXAM REQUESTED
Area to be scanned:
Clinical History:
☐ Priority appointment given to patient prior to discharge
Previous studies: ☐ MRT ☐ CT ☐ X-RAY ☐ US ☐ NM

PHYSICIAN INFORMATION	
Referring Physician:	
Phone #:	Fax #:
Billing #:	CPSO #:
Physician Signature:	

REPORTS TO
Dr.
Dr.
Dr.

THE FOLLOWING MUST BE COMPLETED BEFORE AN MRI CAN BE COMPLETED
Incomplete or illegible requisitions will be returned

PATIENT SCREENING *(complete the following with patient)* *Not performed at PRHC*		
Cardiac pacemaker/leads/defibrillator*	☐ Yes	☐ No
Cochlear implants*	☐ Yes	☐ No
Neurostimulator	☐ Yes	☐ No
Artificial heart valves	☐ Yes	☐ No
Retinal detachment surgery	☐ Yes	☐ No
Aneurysm clips	☐ Yes	☐ No
Transdermal medication patches/electronic skin sensors	☐ Yes	☐ No
Shrapnel/bullets	☐ Yes	☐ No
Other medical implants of any kind	☐ Yes	☐ No
Has the patient had any medical procedure or surgery in the last six weeks?	☐ Yes	☐ No
Does the patient need an interpreter?	☐ Yes	☐ No
If yes, please makes sure they accompany the patient to the appointment		
Contact name: _____		
Is patient pregnant	☐ Yes	☐ No
Has metal ever gone into your eye	☐ Yes	☐ No
If yes, physician must order x-rays of orbits and submit x-ray report with requisition		
Coils, filters or stents	☐ Yes	☐ No
Renal disease	☐ Yes	☐ No
Shunt	☐ Yes	☐ No
Programmable	☐ Yes	☐ No
Patient weight: _____ lbs _____ kg eGFR _____		

Has the patient ever had any surgery on *(Please describe)*		
		Initials
Head		
Spine		
Chest		
Abdomen		
Extremities		
Other		

If patient is claustrophobic, referring physician will prescribe required medication. Patient is responsible for a ride home.