Orillia Soldiers' Memorial Hospital
170 Colborne St. West, Orillia, ON L3V 2Z3 Tel: **705-327-9127** Fax: **705-330-3224**

Request for Magnetic Resonance Imaging (MRI) Examination

(By Appointment Only)

PATIENT INFORMATION	**MRN Nº**	**APPOINTMENT DATE:**	**TIME:**
IN-PATIENT **OUT-PATIENT** **ER**			**ARRIVAL TIME:**

Last Name			**First Name**	
Date of Birth (d/m/y)	**M F**	**Health Card Nº**	**WSIB Nº**	**3rd Party Ins. Nº**
Address				
City	**Postal Code**	**Contact Number**		**OK to leave voice mail message**

PROCEDURE REQUESTED:

For MSK requests, please order general x-ray images of the affected joint if recent imaging has not been completed at OSMH.

RELEVANT CLINICAL HISTORY:

MRI Safety Assessment *Does the patient have any of the following:*

Previous Surgeries: When:

Pacemaker *(absolute contraindication)*	YES	NO
Cerebral aneurysm clips *(absolute contraindication)*	YES	NO
Cochlear implants *(absolute contraindication)*	YES	NO
Brain Operation	YES	NO
Heart Operation	YES	NO
Prosthetic heart valve	YES	NO
Neurostimulator device	YES	NO
Insulin/chemotherapy pump	YES	NO
Coronary bypass graft / vascular stent	YES	NO
Metal rods, plates, screws, nails	YES	NO
Any other metallic, magnetic or electronic implants?	YES	NO
Retained pacing wires	YES	NO
Shrapnel/ bullets	YES	NO
Ocular implant (cataract lens implant safe)	YES	NO
Penile implant	YES	NO
Tissue Expander	YES	NO
Transdermal patches	YES	NO
Hearing Aids	YES	NO
Dentures	YES	NO
Ever had metal fragments in eyes?	YES	NO
If YES, send recent X-ray Orbit Report		
Is the patient pregnant?	YES	NO
Is the patient claustrophobic?	YES	NO
(If Yes, physician to prescribe sedation)		
Allergic to MRI contrast?	YES	NO
Does the patient have mobility issues?	YES	NO

PATIENT WEIGHT: lbs kg PATIENT HEIGHT:

For Paediatric Use Only:

Is general anesthesia required? YES NO

Renal Function Assessment (please check appropriate box)

Hx of Renal Disease	Chemotherapy	Hypertension	
Vascular Disease	Over 70 years	Stroke	
Cirrhosis	On Dialysis	Gout	Diabetes
Patient has NONE of the risk factors			

If YES to any of the above, we require a current creatinine/eGFR in the last 6 months.

CREATININE LEVEL: CR __________ eGFR __________ DATE: __________

FOR DEPARTMENT USE ONLY PRIORITY: P1 P2 P3 P4

Signature:

HEAD	PELVIS	ARTHROGRAM
SPINE	UPPER EXTREMITY	CONTRAST
NECK	LOWER EXTREMITY	FBO X-ray
ABDOMEN	CHEST	

Specify series required:

** NPO Midnight **

** NPO + Fleet Enema 6 hours prior to exam **

20	30	40	50	60

PHYSICIAN INFORMATION

Physician's Name (Please PRINT clearly)		OFFICE STAMP:
Address/ Phone	**CPSO#**	
Physician's Signature X		

INCOMPLETE, ILLEGIBLE AND/OR UNSIGNED REQUISITIONS WILL BE RETURNED.