Diagnostic Imaging
Magnetic Resonance Imaging

Fax: 905-494-6614 Next available appointment **OR** Brampton Civic Hospital Etobicoke General Hospital

Patient Information

Name:______________________________ Date of Birth*(DD/MM/YYYY)*:______________

Health Card No:______________________________ Version Code:______________

Address:______________________ City:__________ Prov.:______ Postal Code:__________

Tel:______________________ Email:______________________

To **request DI exam for discharged ED / UCC patient**, select time frame* for DI exam, and send patient with this requisition to the DI remote / EDDI desk to book DI exam. **Do not fax this requisition.** Less than 24h Less than 48h Less than 10 days Less than 1 month

Section 1 – To be completed by Physician.

Examination Requested

Specified Body Part to be examined: ______________________________	**WSIB Claim #** ______________
Outpatient ED/Inpatient ______________________	Date of Injury: ______________

Clinical Questionnaire

Clinical History (Mandatory):

Relevant Exams – Provide Reports: ______________________________

PATIENT TO COMPLETE LOWER HALF OF REQUISITION	**NOTE:** If patient answers yes to: Question #2 – orbit X-ray report must accompany this requisition. Question #3 – Prescribe sedation. Patient to bring medication on day of appointment. Question #6 or #7 – order a serum creatinine and fax results

Section 2 – To be completed by patient (Pre-Screening)

1)	Have you had a previous MRI?	Not sure	Y	N
2)	Have you ever worked with or had an eye injury involving metal?		Y	N
3)	Are you claustrophobic? if yes, bring sedation & escort with you		Y	N
4)	Are you pregnant? LMP: ______________		Y	N
5)	Do you have allergies? Specify: ______________		Y	N
6)	Do you have a history of acute kidney disease?		Y	N
7)	Do you currently receive dialysis?		Y	N
8)	Do you require an interpreter?		Y	N
9)	Do you wear medication patches on your skin?		Y	N
10)	Do you have an insulin pump or glucose monitor?		Y	N

Do you have

• Pacemaker – past or present	Y	N
• Implantable Cardiac Defibrillator (ICD)	Y	N
• Loop recorder	Y	N
If yes, were any of above implants embedded at Osler?	Y	N
• Aneurysm clips	Y	N
• Coils, filters or stents	Y	N
• Neurostimulator, Biostimulator	Y	N
• Intraventricular shunt in your head	Y	N
• Drug infusion or insulin pump	Y	N
• Magnetically or electronically activated implant/device	Y	N
• Metal plates/screws	Y	N

If yes, specify body part: ______________

Previous Surgery			**Date:**
Head/Neck – brain, ear, eye (excl. cataract)	Y	N	__________
Chest	Y	N	__________
Abdomen	Y	N	__________
Spine	Y	N	__________
Joint(s) replacement	Y	N	__________
If yes, specify body part:			__________
Other:	Y	N	__________

Patient Weight: _______ (kg) Patient Height: _____(cm)

Patient Signature ______________________

DI USE ONLY:

P1 P2 P3 P4

PROTOCOL: Mnemonic:

Provider Name (Print): ______________________ CPSO/OHIP Billing #: ______________

Telephone: ______________________ Fax: ______________________

Copies to (Provider Name): ______________________

Provider Signature: ______________________ Date :______________

***Booking date is dependent on appointment availability and radiologist supervised clinical triaging based on provided clinical history**

NOTE: INCOMPLETE REQUESTS WILL BE RETURNED, RESULTING IN DELAY OF BOOKING

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