COLLINGWOOD
G&M HOSPITAL

Bookings Tel: (705) 444-8670 Fax: (705) 445-7593

CGMH is a scent free facility

MRI REQUISITION

Name: _____

D.O.B: DD/MM/YYYY **Health Card#:**_____

Gender: ◯ **Male** ◯ **Female** ◯ **Other**

Address: _____

City: _____**Postal Code:**_____

Phone # _____ **Cell #** _____

CLINICAL HISTORY / INDICATION:

◯ Urgent ◯ Follow up due_____

Referring Healthcare Provider

Signature: _____

Provider Name: _____

Fax #: _____

Copy to: _____

EXAMINATION REQUESTED:

Brain
- ○ Routine
- ○ CVA/TIA brain
- ○ MS/Demyelination
- ○ Seizure
- ○ Trauma
- ○ Brain MRA COW
- ○ IAC and CN8
- ○ Brain MRV
- ○ Orbits
- ○ Sella/pituitary
- ○ TMJs

Neck
- ○ Carotids/Vertebrals

Spine
- ○ Cervical
- ○ Thoracic
- ○ Lumbar
- ○ Sacrum/Coccyx
- ○ Sacroilliac Joints
- ○ Whole Spine

Other:_____

Abdomen
- ○ Liver/Spleen
- ○ MRCP
- ○ Pancreas
- ○ Adrenals
- ○ Kidneys

Pelvis
- ○ Routine
- ○ Anal Fistula

Musculoskeletal
- ○ Shoulder
- ○ Elbow
- ○ Wrist
- ○ Hand
- ○ Pelvis
- ○ Hip
- ○ Knee
- ○ Ankle
- ○ Foot
- ○ Other MSK _____
- ○ Palpable Lump Workup
  Specify:_____

MRI SAFETY SCREENING:

To prevent delays in scheduling, please provide all relevant information.

◯ **History of metal fragments in eye(s)/body**

Note: *Attach x-ray reports post injury, if available*

◯ **History of active electronic implants**
- ○ Pacemaker/ICD ***(Contraindicated at CGMH)***
- ○ Neurostimulator
- ○ Cochlear Implant ***(Contraindicated at CGMH)***
- ○ Medication Pump

◯ **History of other metal containing devices**
- ○ Aneurysm Clip
- ○ Coils, filters or stents
- ○ Heart Valve
- ○ Orthopedic Device
- ○ Pessary
- ○ Prothesis
- ○ Shunt
- ○ Subdermal Piercings
- ○ Tissue Expander
- ○ Other _____

◯ **None of the above, patient has no metal or electrically conductive implants or devices**

Height: _____ **Weight:** _____ ◯ **kg** ◯ **lbs**

Maximum weight: 550 lbs Maximum Diameter: 70 cm

Dialysis: ◯ YES

Hypersensitivity to Contrast Agents:

◯ YES (*Specify Contrast Agent*: _____)

Pregnant: ◯ YES

History of Claustrophobia: ◯ YES

(referring provider to prescribe sedation)

Mobility: ◯ Wheelchair ◯ Hoyer Lift ◯ Stretcher

Please list **ALL** previous surgeries and approximate dates:

_____

_____

_____

Please attach operative report and provide *make* and *model* for any implanted devices or stents.
Please also include any revelent outside imaging reports.