WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

MRI REQUISITION

Fax Requests to:
Phone: (519) 254-1727 Fax: (519) 255-2125

INCOMPLETE / ILLEGIBLE REQUESTS WILL BE RETURNED - Resulting in delay of appointment booking

Patient Information (Please Print)

Name: _____ Date of Birth (MM/DD/YYYY):_____ Sex: ☐ M ☐ F

Address: _____ WSIB: _____ Patient's Weight: _____ lbs _____ Kgs

Primary Contact: ( )_____ Secondary# ( ) _____ Patient's Height: _____ ft _____ in

Health Card #: _____ Version Code _____ Patient arriving from external healthcare facility ☐ Y ☐ N

AREA TO BE EXAMINED / CLINICAL INFORMATION

RELEVANT PREVIOUS DIAGNOSTIC EXAMS: MR / CT / US / NUC MED / X-RAY - ATTACH REPORTS

Where / When: Result:

Type of Surgery: Where / When:

The following can interfere with the MRI and/or can be a safety hazard. If the following information changes between now and the scheduled appointment please notify the MRI Department. Inaccurate information can result in cancellation of exam.

Pacemaker	☐ Yes	☐ No	Penile Implant	☐ Yes	☐ No
Cochlear Implant	☐ Yes	☐ No	Orthopedic Plate / Pin / Screw	☐ Yes	☐ No
Neurostimulator	☐ Yes	☐ No	Pregnant / Breast Feeding	☐ Yes	☐ No
Implanted Infusion Pump	☐ Yes	☐ No	Hearing Aid	☐ Yes	☐ No
Cerebral Aneurysm Clip	☐ Yes	☐ No	Shrapnel / Bullets / Pellets	☐ Yes	☐ No
Make / Model: _____			Tattoos / Tattooed Eyeliner	☐ Yes	☐ No
Prosthesis:	☐ Yes	☐ No	Body Piercing	☐ Yes	☐ No
Programmable Shunt	☐ Yes	☐ No	Other Implants / Metal	☐ Yes	☐ No
Specify:_____					

Is the patient Claustrophobic?	☐ Yes	☐ No	Does the Patient Require an Oral Sedative prescribed by the referring physician?	☐ Yes	☐ No
Allergies	☐ Yes	☐ No			
Specify: _____					
Does the patient use any physical aids (e.g. walker, cane)?	☐ Yes	☐ No	Has the patient ever had an eye injury, metal in or around eye? (Please attach foreign body orbit report)	☐ Yes	☐ No

Are you over the age of 60?	☐ Yes	☐ No	Renal Disease (solitary kidney, renal transplant, renal tumour)	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No			
Diabetes	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Myocardial infarction	☐ Yes	☐ No	Peripheral vascular disease	☐ Yes	☐ No
Organ transplantation	☐ Yes	☐ No	Chemotherapy for malignancy	☐ Yes	☐ No

If YES to any of these questions, attach most recent lab results with creatinine level.

Print Referring Physician_____ Fax Number:_____

Referring Physician Signature:_____

Physicians who require copy of report:_____

APPOINTMENT:

DATE (MM/DD/YYYY):_____ TIME: _____ CAMPUS:_____