Mackenzie Health

Mackenzie Richmond Hill Hospital
10 Trench Street, Richmond Hill ON L4C 4Z3
905-883-1212

Cortellucci Vaughan Hospital
3200 Major Mackenzie Drive West, Vaughan ON L6A 4Z3
905-417-2000

MRI Requisition

Telephone: 905-883-2004 **Fax: 905-883-2043**

☐ **Other Insurance / WSIB #** _____

MRN: _____

Referring Physician: _____

Billing#: _____

Referring Physician Signature: _____

Additional Reports to: _____

Referring Physician Address: _____

Referring Physician Office Phone: _____

Referring Physician Fax: _____

Patient Name: *(Print Last, First)*

Address:

Health Card Number: **Version Number:** **Date of Birth:** *(dd/mm/yyyy)*

Primary Number: ( ) ☐ **Cell** ☐ **Home** ☐ **Work ( )**

Secondary Phone Number: ( ) ☐ **Cell** ☐ **Home** ☐ **Work ( )**

Clinical History and Diagnostic Questions: ☐ **Cancer screening, diagnosis or staging?**

Specified exam date request? _____ *(dd/mm/yyyy)*

EXAM REQUIRED (check all that apply)

Brain
- ☐ Brain Routine
- ☐ Brain MS
- ☐ Seizure
- ☐ Brain & MRA Cow
- ☐ IAC
- ☐ MRV Head
- ☐ Orbits
- ☐ Sella/Pituitary

Spine
- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar (T11-S2)
- ☐ Sacrum/Coccyx (bone)
- ☐ Lumbosacral Plexus (nerves)
- ☐ Sacroiliac Joints (sacroiliitis)
- Whole Spine
  - ☐ Cord Compression
  - ☐ Metastases

Abdomen
- ☐ Liver
- ☐ MRCP
- ☐ Pancreas & MRCP
- ☐ Spleen
- ☐ Adrenals
- ☐ Kidneys
- ☐ PCKD (renal size only)

Angiogram (with Gadolinium)
- ☐ Subclavians (Bilateral)
- ☐ Renal/Mesenteric
- ☐ Thoracic Outlet
- ☐ Peripheral Runoff
- ☐ Thoracic Aorta ☐ Abdominal Aorta
- ☐ Carotid/Vertebrals ☐ Dissection

Head and Neck
- Brachial Plexus ☐ Right ☐ Left
- ☐ Neck (soft tissue)
- ☐ Parathyroids
- ☐ TMJs
- ☐ Parotids

Chest and Breast
- Breast ☐ Mass/Follow-up
- ☐ Implant
- Chest Mass ☐

Cardiac
- ☐ **Cardiac**
- *Require ECHO report and cardiology consult note.

Pelvis
- ☐ Pelvis
- ☐ Rectal Mass
- ☐ Anal Fistula
- ☐ Testicular Mass
- ☐ Urethra (Female or Posterior Male)

Other Request
- Specify:

Musculoskeletal (Upper Extremity)
- Shoulder ☐ R ☐ L
- Elbow ☐ R ☐ L
- Hand/Wrist (Inflam. Arthritis) ☐ R ☐ L
- Wrist ☐ R ☐ L
- Thumb/Finger – Specify:

Musculoskeletal (Lower Extremity)
- Hip ☐ R ☐ L
- Pelvis (Body) ☐ R ☐ L
- Hamstring (Proximal) ☐ R ☐ L
- Knee ☐ R ☐ L
- Ankle/Hindfoot ☐ R ☐ L
- Achilles Only ☐ R ☐ L
- Forefoot (Osteomyelitis) ☐ R ☐ L
- Hindfoot (Osteomyelitis) ☐ R ☐ L
- Forefoot (Inflammatory) ☐ R ☐ L
- Forefoot Other (e.g. Morton's) ☐ R ☐ L

Palpable Lump Work Up (With Markers)
- Upper Extremity ☐ R ☐ L
- Lower Extremity ☐ R ☐ L
- Specify:
- Body/Other ☐ R ☐ L
- Specify:

3028

(Rev. Nov 16, 2023)

If sedation is required for claustrophobia, please arrange this with your patient. Mackenzie Health MRI will not dispense sedation. If there is a possibility of history of metal being in your patient's eyes, please arrange for orbit xrays to confirm or exclude any metal currently in the eyes. Have the x-ray report sent with this requisition. This will help ensure that the patient's MRI experience goes smoothly.

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Patient Name: _____

Date of Birth: _____
(dd/mm/yyyy)

MRI Requisition

RENAL FUNCTION

☐ No hx of renal disease ☐ Hx of renal disease and not on dialysis (attach eGFR within last 6 months)

☐ Peritoneal dialysis ☐ Hemodialysis (provide schedule, e.g. MWF 14:00) _____

The following items may interfere with MR imaging or be hazardous to your patient's safety. Please indicate all of the following that apply to this patient.

	YES	NO
Pacemaker *** Patients with most pacemakers and implanted defibrillators can be scanned but this must be done at the institution that implanted the device.**	☐	☐
Pacemaker wires not attached to current pacemaker *** Non-grounded intravenous pacing wires are an absolute contraindication to MRI. Consider alternate exam.**	☐	☐
Cochlear implant *** Patients with some cochlear implants can be scanned safely. Please submit make and model of implant for review.**	☐	☐
Cerebral aneurysm clip/coil ***Patients with cerebral aneurysm clips/coils will only be scanned if they have been scanned since implantation at the institution that implanted the clips/coils.**	☐	☐
Implanted insulin/chemotherapy pump (patient must be able to remove prior to scan)	☐	☐
Freestyle Libre device or similar: Indicate date of next device change _____(dd/mm/yyyy)	☐	☐
Neuro or bio stimulator device or programmable ventricular shunt. Specify location and provide model:	☐	☐
Swan Ganz line (or metallic wire tipped catheter)	☐	☐
Surgically implanted metal in ear (e.g. stapes prosthesis). Specify model:	☐	☐
Orbital/eye prosthesis. Specify model if not removable:	☐	☐
Metallic aortic or iliac stents (e.g. Zenith). Specify location:	☐	☐
Artificial joint or metal rod, plate, screw or wire on any bone. Specify location:	☐	☐
Other metallic or partly metallic implant (e.g. tissue expander with magnetic port, penile implant), endoscopy capsule or magnetic dental implant? Specify:	☐	☐
Endoscopy (Gastroscopy or colonoscopy) with biopsy AND clip placement within the past 2 months or any surgery (including laparoscopy) within the past 6 weeks. Send OR note.	☐	☐
Any history of previous metal fragments in the eyes? Patient requires orbit xray prior to scheduling.	☐	☐
Patient currently works with metal (e.g. grinder/welder). Patient requires orbit x-ray the day of MRI. Send requisition with patient.	☐	☐
Shrapnel (gunfire or bomb) fragments in body? Specify location in body and date of injury:	☐	☐
Is patient pregnant? If yes, EDC:	☐	☐
Does patient have allergy to **MRI** contrast media? Specify reaction:	☐	☐
Does your patient have special needs that may impact ability to cooperate with scanning instructions (such as not fluent in English (patient MUST bring an interpreter), cannot hear without hearing aid, cannot transfer from wheelchair to bed alone? Specify:	☐	☐