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 (D/M/Y): ____________________ 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: ______________________ **TIME:** __________ **CAMPUS:** ______________________