ST. MICHAEL'S
UNITY HEALTH TORONTO

8 0 1 8 0

Primary Care MSK/Spine
MRI Requisition

Medical Imaging
30 Bond Street, Toronto, ON M5B 1W8
Website – http://bit.ly/2ucQCPA
Tel.: 416-864-5661
Fax: 416-864-5820

APPOINTMENT
Exam Date: _____
Arrival Time: _____
Exam Time: _____

A. PATIENT INFORMATION

MRN	**DOB:** DD MMM YYYY
Last Name	
First Name	
Street Address	
City	**Postal Code**
Province	**Country**

Health Card #: **VC:**

☐ **Self-pay** ☐ **IFH** ☐ **WSIB Claim #:**_____

☐ **Male** ☐ **Female** ☐ **Intersex** ☐ **Please Specify:**
☐ **Transgender – Female to Male**
☐ **Transgender – Male to Female**

B. EXAM INFORMATION (Auto-protocol requests are without GAD)

☐ Hip	R	L	☐ Bilateral Hips	☐Shoulder	R	L	☐ Bilateral Shoulders	☐ Cervical Spine
☐ Knee	R	L	☐ Bilateral Knees	☐ Elbow	R	L	☐ Bilateral Elbows	☐ Thoracic Spine
☐ Ankle	R	L	☐ Bilateral Ankles	☐ Wrist	R	L	☐ Bilateral Wrists	☐ Lumbar Spine
☐ Foot	R	L	☐ Bilateral Feet	☐ Hand	R	L	☐ Bilateral Hands	

☐ Other_____**RADIOLOGIST TO PROTOCOL**

*** If C, T and L spine are all requested the referral will require the radiologist to review and protocol

Clinical Information (REQUIRED):

Time: ☐ Urgent **(2-10 days)** ☐ Routine **(next available)** ☐ Timed _____

Appointment Preference - optional: ☐ Day (6AM-6PM) ☐ Evening (6PM-11PM) ☐ Night (11PM-6AM)
Communication Preference: ☐ Cell phone: _____ ☐ Landline: _____ ☐ Email: _____
Patient Accommodations: ☐ Language: _____ ☐ Mobility: _____ ☐ Isolation Precaution : _____

Surgery or implants (list all): ☐ No ☐ Yes: _____ Pregnant: ☐ No ☐ Yes
Weight: _____kg Height: _____cm

C. SCREENING QUESTIONS (must be completed)

1. Have you ever had an eye injury from a metal object or required a metal fragment to be removed by a doctor?	Y ☐ N ☐
2. Are you on dialysis?	Y ☐ N ☐

3. Indicate if you have the following:

Cardiac pacemaker or implantable defibrillator (ICD)	Y ☐ N ☐	Drug infusion pump (insulin, antibiotic, etc…)	Y ☐ N ☐
Pacing wires (epicardial)	Y ☐ N ☐	Electronic monitoring device (diabetes, etc…)	Y ☐ N ☐
Neurostimulator/TENS unit	Y ☐ N ☐	Breast tissue expander	Y ☐ N ☐
Cochlear or other ear implant	Y ☐ N ☐	Eye prosthesis or implant	Y ☐ N ☐
Swan Ganz line	Y ☐ N ☐	Shrapnel, bullet, foreign metal object	Y ☐ N ☐
Brain aneurysm clip	Y ☐ N ☐	Metal rods, pins, screws, wires	Y ☐ N ☐
Intravascular stent, filter, coil	Y ☐ N ☐	Medication patch (es)	Y ☐ N ☐
Programmable shunt	Y ☐ N ☐	Other metallic implants (specify…)	Y ☐ N ☐

D. ORDERING PHYSICIAN INFORMATION & SIGNATURE

Ordering Physician Name (please print):	Copy to (please print):
Signature:	Date:
CPSO #:	Billing #:
Fax:	Phone #:

Reset Save