

This form is for physician use only.

Request for MR

PATIENT INFORMATION

Name _____ Date of birth _____ Sex F M Other
Last name, First name Year-Month-Day

Health card _____ Version code _____ Schroeder MRN _____

Address _____

City _____ Postal code _____ Phone 1 _____ Phone 2 _____
Preferred Alternate

SCREENING

PRECAUTIONS

Patient weight kg

Hemodialysis or peritoneal dialysis Y N
SAC does not perform gadolinium exams on dialysis patients

Claustrophobia requiring sedation..... Y N
If yes, referring physician to provide sedation

Chance of pregnancy Y N

Previous reaction/allergy to MRI contrast? Y N

MR SAFETY – To be completed with patient

Previous eye injury involving metal Y N
If yes, orbits x-ray report must be attached

Does patient have:

Pacemaker, defibrillator, implanted cardiac leads Y N

Cochlear (ear) implant Y N

Aneurysm clips, coils, or stents Y N

Artificial heart valve..... Y N

Infusion pump or neurostimulator Y N

Any other surgical implantable device/prosthesis Y N

Shrapnel/bullets..... Y N

Any previous surgery to ears, eyes, brain, or heart Y N

Any medical procedure or surgery in last 6 weeks Y N

Provide details of MR safety (attach relevant operative notes/
manufacturer and model number of implantable devices):

REGION TO BE EXAMINED

CLINICAL INDICATION/RELEVANT HISTORY

Relevant previous imaging reports must be attached

BILLING

OHIP WSIB claim # _____ Other _____

REFERRING PHYSICIAN

Name, address, fax, phone, billing number:

Physician Name _____

Physician Address _____

Phone _____ Fax _____

Physician Billing Number _____

Send copies to:

MR Safety questions have been reviewed with patient
MANDATORY

Signature **X** _____ Date _____