HEADWATERS Health Care Centre

**Diagnostic Imaging Requisition**

**Fax completed requisitions to 519-941-7726**

**OFFICE USE ONLY**
Exam Date: _____
Arrival Time: _____
Exam Time: _____

# MRI Requisition

**Clear Form**

## PATIENT INFORMATION

Last Name, First Name:

Health Card # VC:

DOB DD/MM/YYYY ☐ M ☐ F ☐ Other

WSIB? ☐ Y ☐ N Injury Date: DD/MM/YYYY

Street Address:

Employer: Please Include Claim #:

City/Town

Other Insurance? Third Party or Self Pay

Province: Postal Code:

Specify:

Email Address

## CONTACT NUMBER: PATIENT CONSENT TO LEAVE MESSAGE

Home: ☐ Yes ☐ No

Other: ☐ Yes ☐ No

Preferred Language: ☐ English ☐ Other:

Interpreter required? ☐ Yes ☐ No

## REFERRING PHYSICIAN

Name:

Address:

Telephone: Fax:

## REQUIRED PATIENT INFORMATION

Height: Weight: Sex: ☐ M ☐ F ☐ Other

**If Patient weight greater than 550lbs, the MRI may not be booked due to table restrictions.**

☐ Restricted Mobility ☐ Falls Risk

☐ Require Hoyer Lift (***Sling must be placed under patient prior to MRI arrival***)

☐ Patient Transport: ☐ W/C ☐ Stretcher ☐ Ambulatory ☐ Ambulance Transfer

☐ Pediatric Under 10 years

**IMAGING UNDER GENERAL ANESTHESIA IS NOT CURRENTLY OFFERED**

## EXAM INFORMATION: PHYSICIAN TO COMPLETE ** INCOMPLETE REQUISITIONS WILL BE RETURNED**

**Urgency:** ☐ Urgent (<72hrs contact dept.) ☐ Semi-Urgent ☐ Routine

**Clinical History & Diagnostic Questions:** ☐ **CANCER SCREENING DIAGNOSIS OR STAGING?**

## NEURO BRAIN

☐ Brain
☐ Neck
☐ MS/demyelination
☐ Seizure
☐ IAC
☐ Orbits
☐ Sella/Pituitary
☐ TMJ
☐ Brachial Plexus ☐ L ☐ R

## NEURO SPINE

☐ Cervical
☐ Thoracic
☐ Lumbar
☐ Sacroiliac Joints
☐ Sacrum/Coccyx

## WHOLE SPINE

☐ Cord Compression (Provide Level of interest)
☐ Metastases
State Primary:

## THORAX AND BREAST

☐ Mediastinal Mass

**AVAILABLE JANUARY 2026**

Breast: ☐ Mass/Follow-up ☐ OBSP Screening ☐ Cancer Screening

## ANGIOGRAM

☐ MRA Head Cow
☐ MRV Dural Venous Sinus
☐ Renal Mesenteric Arteries
☐ MRA Neck Carotids/Vertebral Arteries:
☐ Routine ☐ Dissection

## ABDOMEN AND PELVIS

☐ Liver/Spleen
☐ MRCP Only
☐ Pancreas (includes MRCP)
☐ Enterography
☐ Adrenals
☐ Kidneys
☐ Male Pelvis
☐ Female Pelvis
☐ Cervix
☐ Prostate
☐ Rectum
☐ Anal Fistula
☐ Testicles

## PALPABLE LUMP WORK UP

Body/Other – Specify:

**MRI CARDIAC IMAGING CURRENTLY NOT AVAILABLE**

## MUSCULOSKELETAL (UPPER EXTREMITY)

☐ Shoulder ☐ L ☐ R
☐ Elbow ☐ L ☐ R
☐ Forearm ☐ L ☐ R
☐ Wrist ☐ L ☐ R
☐ Hand ☐ L ☐ R
☐ Thumb/Finger (ordered by Ortho only)
Specify: _____
☐ Palpable Lump Workup – Specify:

## MUSCULOSKELETAL (LOWER EXTREMITY)

☐ Hip ☐ L ☐ R
☐ Femur/Thigh ☐ L ☐ R
☐ Knee ☐ L ☐ R
☐ Tibia Fibula/Calf ☐ L ☐ R
☐ Foot ☐ L ☐ R
☐ Ankle ☐ L ☐ R
☐ Foot ☐ L ☐ R
☐ Osteomyelitis -Specify area of interest:
☐ Palpable Lump - Specify:

## INTRAVENOUS ACCESS

IV Access in situ: ☐ Port ☐ PICC

## OTHER REQUEST *(NOT LISTED ABOVE)*

Specify:

HEADWATERS
Health Care Centre

**Diagnostic Imaging Requisition**

**Fax completed requisitions to 519-941-7726**

**OFFICE USE ONLY**
Exam Date: _____
Arrival Time: _____
Exam Time: _____

# MRI Requisition

| **Renal Assessment:** | | | | |
|---|---|---|---|---|
| Kidney problems/disease | ☐ Y | ☐ N | If you have answered yes to any of the Renal Assessment questions, a Creatinine and eGFR within the last 3 months must be provided | |
| Dialysis | ☐ Y | ☐ N | | |
| Acute Kidney Injury | ☐ Y | ☐ N | Creatine: | Date: |
| Previous Allergy to MRI Contrast | ☐ Y | ☐ N | eGFR: | Date: |

| **DO YOU HAVE ANY OF THE FOLLOWING:** | | | | | | |
|---|---|---|---|---|---|---|
| Cardiac pacemaker/pacing wires/ implanted cardiac defibrillator | ☐ YES | ☐ NO | Pessary or bladder ring | ☐ YES | ☐ NO |
| Aneurysm clip or brain clip | ☐ YES | ☐ NO | Medication Transdermal Patch | ☐ YES | ☐ NO |
| Cochlear, otologic or inner ear implant | ☐ YES | ☐ NO | Glucose monitoring sensor ***(Remove before scan)*** | ☐ YES | ☐ NO |
| Intravascular stents, filters, or coils | ☐ YES | ☐ NO | Hearing aids ***(Remove before scan)*** | ☐ YES | ☐ NO |
| Neurostimulator device | ☐ YES | ☐ NO | Any external fixators? | ☐ YES | ☐ NO |
| Insulin or drug infusion pump | ☐ YES | ☐ NO | Have you ever had metal in your eyes | ☐ YES | ☐ NO |
| Shunt (spinal or intraventricular/programmable) | ☐ YES | ☐ NO | Tissue expander (breast) | ☐ YES | ☐ NO |
| Carotid artery vascular clip | ☐ YES | ☐ NO | Artificial limb or joint | ☐ YES | ☐ NO |
| Heart valve prosthesis | ☐ YES | ☐ NO | Shrapnel. Buckshot, or bullets | ☐ YES | ☐ NO |
| IUD (type) | ☐ YES | ☐ NO | Prosthesis (penile, eye, ear, etc.) | ☐ YES | ☐ NO |
| Are you pregnant | ☐ YES | ☐ NO | Any metallic/ electronic implant or device held in place by a magnet | ☐ YES | ☐ NO |

List all Previous Surgeries and Implants: ☐ No Previous Surgeries or Implants

**For any implant, provide surgery date and/or hospital name to verify it is safe to proceed with MRI. Provide OR records to expedite booking.**

**Note:** If sedation is required for claustrophobia, please arrange this with your patient, MRI Department will not dispense sedation. If there is a possibility or history of metal being in your patient's eyes, please arrange for orbit x-rays to confirm or exclude any possible metal in the eyes. Have the x-ray report sent with this requisition. This will help ensure that the patient's eyes are clear from metal and can proceed with MRI.

**REFERRING PHYSICIAN:**

_____ Print Name

_____ Signature

_____ Date

Billing Number: _____ CPSO Number: _____