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

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:

CONTACT NUMBER: **PATIENT CONSENT TO LEAVE MESSAGE**

Home: ☐ Yes ☐ No

Other: ☐ Yes ☐ No

Preferred Language: ☐ English ☐ Other:

Interpreter required? ☐ Yes ☐ No

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

REFERRING PHYSICIAN

Name:

Address:

Telephone: Fax:

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:

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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: _____