REQUEST FOR MRI CONSULTATION

MRI Department
AG 256 - 2075 Bayview Avenue
Toronto, Ontario M4N 3M5

For Appointment or Information
Tel: 416.480.6177 Fax: 416.480.7841
Internal to Sunnybrook Fax to 7841

PATIENT INFORMATION

Sunnybrook MRN: ______________________ ☐ Outpatient
Health Card: ______________________ ☐ Inpatient __________ Ward
Patient Name (First, Last): ______________________
Sex: ☐ Male ☐ Female ☐ ________ DOB: ________ Weight: ______ Height: ______
Address: ______________________
____
Tel No.: ______________ Email: ______________

Exam Billing (check ☑): ☐ OHIP ☐ WSIB* ☐ Research*
☐ Other (specify): ______________________
*Provide REB Project ID or WSIB Number
____

REGION TO BE EXAMINED

CLINICAL INFORMATION

Physician (PRINT NAME): ______________________
Physician (Signature): ______________________
OHIP Number: ______________________
Address: ______________________
____
Tel: ______________ Fax: ______________

MANDATORY

Patient Safety Screening (To be completed with the patient)
All questions must be answered or this form will be returned

Source of Safety Screening Information: ☐ Patient **OR**
☐ Family/caregiver* ☐ Other* *Contact Information:
Name: ______________________
Relationship: ______________________
Phone number can be reached at: ______________________

1. Previous MRI exam ☐ Yes ☐ No
2. Previous allergic reaction to an MRI contrast agent ☐ Yes ☐ No
3. Possibility of pregnancy ☐ Yes ☐ No
4. Claustrophobic ☐ Yes ☐ No
   If Yes, referring MD to provide sedative
5. Quadriplegia/paraplegia (requires assistance to move) ☐ Yes ☐ No
6. Ambulance or Wheeltrans transportation ☐ Yes ☐ No
7. Has metal ever gone into the patients eye ☐ Yes ☐ No
   If yes, has it been removed by a physician? ☐ Yes ☐ No
8. Other metallic foreign body/shrapnel* ☐ Yes ☐ No
9. Implanted cardioverter defibrillator (ICD)* ☐ Yes ☐ No
10. Cardiac pacemaker* ☐ Yes ☐ No
11. Eye/ear implant* ☐ Yes ☐ No
12. Magnetic or electronically activated implant/device* ☐ Yes ☐ No
13. Cerebral aneurysm clip(s)* ☐ Yes ☐ No
14. Metallic stent/filter/coil* ☐ Yes ☐ No
15. Tissue expander* ☐ Yes ☐ No
16. Intrauterine device (IUD)* ☐ Yes ☐ No
17. Orthopaedic hardware or prosthesis* ☐ Yes ☐ No
18. Insulin or other infusion pump ☐ Yes ☐ No
19. Transdermal patch or CGM* (Continuous Glucose Monitor) ☐ Yes ☐ No
20. Other implants/devices* ☐ Yes ☐ No
21. Is the patient on dialysis ☐ Yes ☐ No
    ☐ Peritoneal dialysis ☐ Hemodialysis
22. Does the patient have an acute kidney injury? ☐ Yes ☐ No

* Provide more information below; clarify what type of device/implant and when it was inserted

Additional Device / Implant information:

More information about Sunnybrook MRI can be found at sunnybrook.ca/medicalimaging