Kingston MRI
The Picture of Health

776 Blackburn Mews East * Kingston, Ontario K7P 2N7
Tel (613) 384-1220 * Fax (613) 384-9492
info@kingstonmri.com * www.kingstonmri.com

Affix patient sticker here
(office use only)

Patient Name: _____ **Referring Physician:** _____

Address: _____ **Physician Signature:** _____

City: _____ **Telephone #:** _____

Telephone (h): _____ **c.c. Physician:** _____

Telephone (w): _____

Date of Birth: _____ ☐**WSIB Claim** **Claim #:** _____

Health Card #: _____ **Check One:** **Walking** ☐ **Wheelchair** ☐ **Stretcher** ☐

REGION TO BE EXAMINED:

☐Brain	☐C-Spine	☐Breasts	☐Hip	☐Liver	☐MRCP/Pancreas
☐Orbits	☐T-Spine	☐Shoulder	☐Knee	☐Adrenals	☐Uterus
☐Neck	☐L-Spine	☐Wrist	☐Ankle	☐Kidneys	☐Ovaries
☐TMJ	☐Brachial Plexus	☐MR Angiogram: _____			☐Other: _____

Reason for Scan: ☐Diagnosis ☐Surgical Planning ☐Cancer Staging/Dx ☐Follow Up ☐Breast Cancer Screening

Priority Code: **1 – Emergent** **2 – Within 48 hours** **3 – Within 10 days** **4 – Beyond 10 days**

Clinical Information: _____

Previous Imaging (eg: MR/CT/US/Angio/Nuc Med): _____

Patient Screening (to be completed by the referring physician on behalf of the patient):

Is the patient claustrophobic? ☐ **Yes** ☐ **No** **(If yes and the patient requires sedation, please DO NOT instruct them to take medication prior to arrival in the clinic. NOTE: SCRIPT FOR SEDATION MUST BE PROVIDED BY THE REFERRING PHYSICIAN)**

Does the patient have:

	Yes	No		Yes	No
Cardiac pacemaker/leads	☐	☐	Neurostimulator/Implanted pump	☐	☐
Artificial heart valve	☐	☐	Cochlear Implants	☐	☐
Aneurysm clips	☐	☐	Shrapnel/bullets	☐	☐
Port-a-cath/Swan Ganz Catheter	☐	☐	Penile Implants	☐	☐
Any surgery (if yes, please describe)	☐	☐			

_____

Is the patient pregnant? ☐ ☐

Does the patient have a patch to deliver medication? ☐ Yes ☐ No

Has metal ever gone in or close to the patient's eyes? ☐ Yes ☐ No

If yes, orbital x-rays are required. Please submit report with this requisition.

RADIOLOGIST USE ONLY

Priority Code: 1 2 3 4

Protocol: _____ Gadolinium: ☐ Yes ☐ No

Radiologist Signature: _____ Scan by Date: _____

Date: _____ Scan Length: _____

This requisition form can be taken to any licensed facility providing healthcare services including hospitals and IHFs such as those listed on the IHF Program website http://www.health.gov.on.ca/en/public/programs/ihf/facilities.aspx