****Incomplete requisitions will be returned, which may delay booking ****

ROSS MEMORIAL HOSPITAL
Kawartha Lakes

MRI REQUISITION

10 Angeline Street North
Lindsay, Ontario
K9V 4M8

Tel. 705 – 328 – 6299
Fax 705 – 328 – 6197

Area to be examined:

Diagnostic Question / Clinical History:

Has there been previous relevant imaging? ☐ Yes ☐ No
Imaging: ☐ MRI ☐ X-ray ☐ CT ☐ US ☐ NM ☐ Mammo

Where/When? _____

Mandatory: Attach relevant imaging reports (except RMH reports)

Name: _____
Address: _____
City/PC: _____
Health Card: _____
DOB (mm/dd/yy): _____
Telephone #: _____
MRN: _____
Patient Type (*Circle*) : IP OP or Emerg
WSIB Claim ☐ Yes #: _____
Referring Physician: _____
Address: _____
Tel #: _____ Fax: _____
Copy to: _____ Fax: _____
Copy to: _____ Fax: _____

Please Review this section with your Patient

Cardiac Pacemaker, Implanted Defibrillator Neurostimulator or Lead/wires for these devices? ☐ Yes ☐ No

The above are Absolute Contraindications for MRI @RMH

Bullets / Shrapnel in body? *Specify where*_____ ☐ Yes ☐ No
Pregnant or Breast feeding? *Specify which* _____ ☐ Yes ☐ No
Insulin or chemotherapy pump? *Specify which* _____ ☐ Yes ☐ No
Aneurysm Clips, Cochlear, Eye / Ear implants or other implanted devices? ☐ Yes ☐ No

Provide make/mode or attach surgical notes: _____

History of Metallic Fragments in the Eye? ☐ Yes ☐ No

Attach orbital x-ray report/can arrange for x-ray on the day of MRI

Requires sedation for claustrophobia / pain? ☐ Yes ☐ No

Prescribed by ref. physician (not to take before arrival)

Have any physical or communication difficulty? ☐ Yes ☐ No

*Specify:*_____

Surgical History	Dates	Specify	
Head/Eye Surgery	_____	_____	☐ Yes ☐ No
Chest Surgery	_____	_____	☐ Yes ☐ No
Spine Surgery	_____	_____	☐ Yes ☐ No
Other Surgery	_____	_____	☐ Yes ☐ No

Patient Weight: (kg)_____ Height: (cm) _____

Patient is on Dialysis?
☐No
☐Yes-Hemodialysis
☐Yes-Peritoneal Dialysis

Radiologist Use Only

Priority Code 1 2 3 4 T
☐ Cancer Stg/Dx ☐ Other ☐ High Risk Breast
Monitor: ☐ Yes ☐ No
Protocol Code/Details:

Contrast ☐ Yes ☐ No Volume _____

Radiologist _____
☐ Screening Required _____
☐ Non-Rad Day ☐ Sedation ☐ Orbits ☐ NPO
Appt. Date: _____ Arrival Time: _____

Attached: ☐ DART ☐ eGFR ☐ Reports ☐ Images

Patient Signature _____ Daytime #: _____ Can patient come on short notice? ☐ Yes ☐ No

Physician Signature _____ _____
Date

Requisition Rec'd - Date: _____ Time: _____ Initials: _____

Appointment Created Date: _____ Time: _____ Initials: _____ RMH FM # 1595 11/2024