

Waterloo Wellington Hospitals

MRI Requisition

Fax completed requisition to ONE Hospital:

- Cambridge Memorial Hospital: (CMH) **519-740-4969**
- Grand River Hospital: (GRH) **519-749-4296**
- St. Mary's General Hospital (SMGH) **519-749-4296**
- Guelph General Hospital: (GGH) **519-837-6423**

OFFICE USE ONLY

Exam Date: _____
Arrival Time: _____
Exam Time: _____

Patient Information

Other Reqs Associated to Patient? Y N

Last Name, First Name: _____ DOB: DD/MM/YYYY <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown Street Address: _____ City/Town: _____ Province: _____ Postal Code: _____ Contact Number: _____ Email: _____ Home: _____ <input type="checkbox"/> Y <input type="checkbox"/> N Patient consents to leave message Other: _____ <input type="checkbox"/> Y <input type="checkbox"/> N Patient consents to leave message Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____ <input type="checkbox"/> Y <input type="checkbox"/> N An interpreter is required to consent to the procedure. CMH, GGH, GRH and SMGH have interpretation services available.	Health Card #: _____ VC: _____ WSIB? <input type="checkbox"/> Y <input type="checkbox"/> N Injury Date: DD/MM/YYYY Please include Claim #: _____ Other Insurance? Third Party or Self Pay Specify: _____ Required Patient Information: Height: _____ (cm) Weight: _____ (kg) <input type="checkbox"/> Restricted Mobility <input type="checkbox"/> Outpatient <input type="checkbox"/> Pediatric Under 10 yrs <input type="checkbox"/> In-Patient Rm/Loc
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EXAM INFORMATION: PHYSICIAN TO COMPLETE **INCOMPLETE REQUISITIONS WILL BE RETURNED**

<p>Urgency: <input type="checkbox"/> Urgent <input type="checkbox"/> Semi-Urgent <input type="checkbox"/> Routine</p> <p>Region/Organ of Interest:</p> <p>Clinical History/Indication (reason for exam):</p> <p>Previous Relevant Imaging and Surgery (please specify):</p> <p>Ordering Physician Name (Please print): _____ Contact #: _____ Fax#: _____</p> <p>Ordering Physician Signature _____ Date _____</p>	<p>Patient Safety Screening (physician to complete with patient)</p> <p><input type="checkbox"/> Y <input type="checkbox"/> N Cardiac Pacemaker* <input type="checkbox"/> Y <input type="checkbox"/> N Implanted Cardioverter Defibrillator(ICD)* <input type="checkbox"/> Y <input type="checkbox"/> N Leads/Electrodes/Internal Wires* <input type="checkbox"/> Y <input type="checkbox"/> N Cochlear Implant* <input type="checkbox"/> Y <input type="checkbox"/> N Tissue Expanders <input type="checkbox"/> Y <input type="checkbox"/> N Metallic Stent/Filter/Coil* <input type="checkbox"/> Y <input type="checkbox"/> N Cerebral Aneurysm Clip* <input type="checkbox"/> Y <input type="checkbox"/> N Metallic Foreign Body to Eye(s) (If YES, orbital X-Ray report must accompany request) <input type="checkbox"/> Y <input type="checkbox"/> N Claustrophobic (If YES, physician must provide sedation and patient be accompanied) <input type="checkbox"/> Y <input type="checkbox"/> N Pregnant <input type="checkbox"/> Y <input type="checkbox"/> N Breastfeeding *Implants of any kind? Specify Type/Make/Model #/Date _____</p> <p>Any surgery/tattoos in the last 6 weeks? Specify Type/Date _____</p> <p>Renal Assessment (If YES to any of the questions below, creatinine is required) <input type="checkbox"/> Y <input type="checkbox"/> N Dialysis <input type="checkbox"/> Y <input type="checkbox"/> N Acute Kidney Injury/Chronic Kidney disease <input type="checkbox"/> Y <input type="checkbox"/> N Inpatient Creatinine: _____ Date: _____ eGFR: _____ Date: _____</p> <p style="text-align: center;">DI OFFICE USE ONLY</p> <table style="width: 100%;"><tr><td style="width: 70%;">Protocol: _____ <input type="checkbox"/> IV</td><td style="width: 30%;">WTIS Priority <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 T: _____</td></tr><tr><td>Initial: Rad _____ Tech _____</td><td>WTIS Reason <input type="checkbox"/> Staging/Diagnosis Ca <input type="checkbox"/> Breast Ca Screening <input type="checkbox"/> Other</td></tr></table> <p>Requisition Received Date/Time _____ DD / MM / YYYY _____ HR / MM</p>	Protocol: _____ <input type="checkbox"/> IV	WTIS Priority <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 T: _____	Initial: Rad _____ Tech _____	WTIS Reason <input type="checkbox"/> Staging/Diagnosis Ca <input type="checkbox"/> Breast Ca Screening <input type="checkbox"/> Other
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Initial: Rad _____ Tech _____	WTIS Reason <input type="checkbox"/> Staging/Diagnosis Ca <input type="checkbox"/> Breast Ca Screening <input type="checkbox"/> Other				

Please indicate location of Imaging examination for Patient:

Cambridge Memorial Hospital Telephone: 519-740-4968
700 Coronation Blvd. Fax: 519-740-4969
Cambridge ON N1R 3G2 www.cmh.org

- MRI Service is located on the **1st Floor** of the hospital's **C Wing**. All patients are asked to register in the MRI Department at their arrival time.

Grand River Hospital Telephone: 519-749-4262
835 King St. W Fax: 519-749-4296
Kitchener ON N2G 1G3 www.grhosp.on.ca

- MRI Service is located in the hospital's Department of Medical Imaging on the **2nd Floor** of the hospital's **D Wing**. All patients are asked to register in the Department of Medical Imaging at their arrival time.
- After hour MRI patients, please enter through the Emergency Department entrance.

St. Mary's General Hospital (SMGH) Telephone: 519-749-4262
911 Queen's Blvd Fax: 519-749-4296
Kitchener ON N2M 1B2 www.smgh.ca

- All patients are to register in the hospital's Diagnostic Imaging Department, located on the 1st Floor, at the indicated arrival time.

Guelph General Hospital Telephone: 519-837-6413
115 Delhi St. Fax: 519-837-6423
Guelph ON N1E 4J4 www.gghorg.ca

- MRI Service is located in the hospital's Diagnostic Imaging Department on the **3rd Floor** of the hospital. All patients are to register in the Diagnostic Imaging department at their arrival time.

How to prepare for your MRI Examination

Important

- For Abdomen/Pelvis MRI Examinations: Do not eat or drink anything for 4 hours prior to your arrival time.
- For all exams: If possible, limit the amount of metallic objects on your person prior to arriving for your examination. You will be asked to remove any hairpins, eyeglasses, jewellery, dental work, hearing aids and any other metallic objects on your person. You will be asked to change into a hospital gown.
- Please be prepared to remove any medication patches prior to your exam
- If you are claustrophobic (uncomfortable in small places), please arrange for medication with your doctor. If you are prescribed medication to help you relax during the examination, please make sure you have someone to accompany you home.
- If you have worked with metal or have had metal in your eyes, please arrange with your doctor to have eye xrays prior to your MRI.
- If you have shrapnel or bullets embedded in tissue, please arrange with your doctor to have xrays of the affected area prior to your MRI

Important

- Please bring your **Ontario Health Card** and this form to your appointment
- **Patients must be able to consent to the procedure. If language is a barrier, please bring an interpreter.**
- If you are unable to keep your appointment, please give us 24 hours' notice
- We kindly ask that you do not wear or apply fragrances in support of our Fragrance Free policies.