

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**
 Guelph General Hospital: (GGH) **519-837-6423**

OFFICE USE ONLY	
Exam Date:	_____
Arrival Time:	_____
Exam Time:	_____

Patient Information		Other Reqs Associated to Patient? <input type="checkbox"/> Y <input type="checkbox"/> N	
Last Name, First Name: _____		Health Card #: _____	VC: _____
DOB: DD/MM/YYYY <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	WSIB? <input type="checkbox"/> Y <input type="checkbox"/> N	Injury Date: DD/MM/YYYY	
Street Address: _____		Please include Claim #: _____	
City/Town: _____		Other Insurance? Third Party or Self Pay	
Province: _____	Postal Code: _____	Specify: _____	
Contact Number: _____		Required Patient Information:	
Home: _____ <input type="checkbox"/> Y <input type="checkbox"/> N Patient consents to leave message	Height: _____ (cm)	Weight: _____ (kg)	
Other: _____ <input type="checkbox"/> Y <input type="checkbox"/> N Patient consents to leave message	<input type="checkbox"/> Restricted Mobility	<input type="checkbox"/> Outpatient	
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pediatric Under 10 yrs	<input type="checkbox"/> In-Patient Rm/Loc	
<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.		_____	

EXAM INFORMATION: PHYSICIAN TO COMPLETE **INCOMPLETE REQUISITIONS WILL BE RETURNED**		
Ordering Physician Name (Please print): _____	Signature _____	Urgency
Contact #: _____ Fax#: _____	Date _____	<input type="checkbox"/> Urgent
		<input type="checkbox"/> Semi-Urgent
		<input type="checkbox"/> Routine

Region/Organ of Interest:	Patient Safety Screening (physician to complete with patient)
Clinical History/Indication (reason for exam):	<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
	Previous Relevant Imaging and Surgery (please specify):

DI OFFICE USE ONLY	
Protocol:	WTIS Priority
Initial: Rad Tech	<input type="checkbox"/> 1
	<input type="checkbox"/> 2
Requisition Received Date/Time	<input type="checkbox"/> 3
	<input type="checkbox"/> 4
_____ DD / MM / YYYY _____ HR / MM	T: _____
	WTIS Reason
	<input type="checkbox"/> Staging/Diagnosis Ca
	<input type="checkbox"/> Other
	Creatinine: _____ Date: _____ eGFR: _____ Date: _____

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.

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.