



Patient Name: _____

DOB: _____

HCN: _____

Address: _____

Phone/Cell #: _____

Non OHIP Patient:

WSIB #:

Physician Name: _____

Physician Signature: _____

OHIP Billing Physician Name/#: _____

Physician Contact #: _____

Physician Fax #: _____

Date of Referral: _____

Report Copies To: _____

****Message capable Physician phone # to confirm receipt of urgent results:**

**if absent, urgent result receipt confirmation delays may occur

INCOMPLETE or ILLEGIBLE requisitions WILL BE RETURNED and may DELAY THE STUDY .

PLEASE FAX COMPLETED REQUISITION TO 613-354-8231

BODY PART(S) TO BE IMAGED-BE SPECIFIC : _____

CLINICAL INDICATION (incl. relevant prior surgery):

Patient is pregnant: _____ weeks

Requested date/time frame: _____

Note: DI Department triages requests based on provided history

Please Circle One:

P2 = Within 48hr **# required **P3 = Within 10 days = P3c Oncology**

P4 = Routine = P4c Oncology

PATIENT SCREENING (complete with patient) *YES = not performed @ LACGH

YES / NO PACEMAKER*/ICD*/LEADS*/Loop*

YES / NO STIMULATION DEVICE* (NEURO/BIO)

YES / NO INNER EAR SURGERY/COCHLEAR IMPLANT*

YES / NO PRIOR BRAIN ANEURYSM CLIPS*

YES / NO OTHER BRAIN SURGERY —SPECIFY _____

YES / NO PRIOR VASCULAR SURGERY —SPECIFY _____

YES / NO SHRAPNEL OR BULLETS-WHERE _____

YES / NO HAVE YOU EVER HAD A PENETRATING EYE INJURY FROM METAL? **IF YES, ORBITAL XRAY IS REQUIRED UNLESS A PREVIOUS MRI OR CT HEAD COMPLETED AFTER EXPOSURE/EVENT.**

CT/MRI HEAD EXAM DATE: _____

PATIENT SCREENING (complete with patient)

YES / NO CURRENTLY ON DIALYSIS?
LOCATION/FACILITY _____

YES / NO CLAUSTROPHOBIC?
 PRESCRIPTION FILLED (Ativan 1 OR 2mg PO prn)
 GIVEN TO PATIENT

YES / NO KNOWN **GADOLINIUM** CONTRAST ALLERGY?
IF YES (Circle & Specify Below)

Minor Reaction (ie. Hives, Itchy, nausea)

Major Reaction (ie. Anaphylaxis)
•non contrast exam only performed

PATIENT WEIGHT _____ **lbs/kg**
MRI table weight restriction: 550 lbs/250kg