Trillium Health Partners
Better Together

DIAGNOSTIC IMAGING REQUISITION
Magnetic Resonance Imaging

Credit Valley Hospital
Booking Line: 905-813-1100 x4517, press 2 for MRI
Fax: 905-813-4172

Mississauga Hospital
Booking Line: 905-848-7554, press 2 for MRI
Fax: 905-848-7295

PATIENT INFORMATION

NAME: _____
SURNAME FIRST NAME

ADDRESS: _____
STREET APT #

_____
CITY POSTAL CODE

PHONE: H_____ W _____

DOB: (D/M/Y) _____ SEX: ◯ M ◯ F

HEALTH CARD #: _____

IS THIS A WSIB CLAIM? ◯ YES ◯ NO

CLAIM #: _____

PRIORITY: ☐ URGENT (WITHIN 1 WK) ☐ SEMI-URGENT (2-8 WKS) ☐ ELECTIVE

AREA TO BE EXAMINED: (Be specific)

_____

_____

_____

CLINICAL INFORMATION: _____

_____

_____

_____

WORKING DIAGNOSIS:

_____

REFERRING MD SIGNATURE

_____

☐ INPATIENT ☐ OUTPATIENT
☐ NON-RES ☐ DIALYSIS PATIENT

Mobility Status:
☐ **Ambulatory**
☐ **Assist with help**
☐ **Non-Ambulatory - lifting assistance required**

PATIENT SCREENING (MUST BE COMPLETED WITH PATIENT)

PLEASE CHECK THE FOLLOWING

	YES	NO
1. HAVE YOU EVER HAD A PREVIOUS MRI?	☐	☐
2. HAVE YOU EVER WORKED AS A METAL GRINDER OR WELDER?	☐	☐
3. HAVE YOU EVER HAD A KNOWN INJURY TO YOUR EYE WITH METAL	☐	☐
4. IS THERE ANY CHANCE THAT YOU COULD BE PREGNANT?	☐	☐
5. ARE YOU CLAUSTROPHOBIC?	☐	☐

(IF YES, MEDS TO BE PROVIDED BY REFERRING PHYSCIAN)

6. DO YOU HAVE THE FOLLOWING?

CARDIAC PACEMAKER OR LEADS STILL IN PLACE	☐	☐
COCHLEAR OR EAR IMPLANTS	☐	☐
EYE SURGERY OR IMPLANTS (EXCLUDING CONTACTS & CATARACTS)	☐	☐
CEREBRAL ANEURYSM CLIPS	☐	☐
HEART VALVE REPLACEMENT	☐	☐
SHRAPNEL, BULLETS, EVER BEEN SHOT?	☐	☐
JOINT REPLACEMENTS/PROSTHESIS	☐	☐
INTRAVASCULAR COIL/FILTER.STENT	☐	☐
SURGICAL CLIPS OR STAPLES	☐	☐
TISSUE EXPANDER	☐	☐
IMPLANTED DEVICES/CATHETER/NEUROSTIMULATORS	☐	☐
VASCULAR ACCESS PORT (PORT-A-CATH, SWAN GANZ)	☐	☐
IUD/DIAPHRAGM	☐	☐
PAIN PUMP, INSULIN PUMP	☐	☐
MEDICATION PATCH ON SKIN (NICOTINE, NITRO)	☐	☐
PENILE PROSTHESIS	☐	☐
HEARING AID	☐	☐
PIERCINGS	☐	☐
TATTOO/PERMANENT MAKEUP	☐	☐
DENTURES	☐	☐

PATIENT WEIGHT: _____ Kgs

7. PLEASE INDICATE ALL SURGICAL HISTORY:
(SPECIFY AREA, TYPE, DATE)

☐ HEAD _____

_____

☐ NECK _____

_____

☐ SPINE _____

_____

☐ CHEST _____

_____

☐ ABDOMEN _____

_____

☐ EXTREMITY _____

_____

PATIENT SIGNATURE: _____

TECHNOLOGIST: _____

REFERRING PHYSICIAN INFO:

ADDRESS: _____

_____ POSTAL CODE: _____

P ( ) _____

F ( ) _____

COPIES TO: _____

OTHER RELEVANT TESTS & RESULTS

MRI: _____

CT/ANGIO: _____

X-RAY: _____

US: _____

2964 D (February/2025)