

PATIENT INFORMATION				
SURNAME		FIRST NAME		MIDDLE INITIAL
ADDRESS			CITY	PROVINCE POSTAL CODE
MOBILE PHONE #	ALTERNATE PHONE #		EMAIL	
Patient consents to appointment information being disclosed to them via text or e-mail: <input type="checkbox"/> Yes, text <input type="checkbox"/> Yes, email				
SEX ASSIGNED AT BIRTH	GENDER IDENTITY		D.O.B. (YYYY/MM/DD)	HEIGHT (CM) WEIGHT (KG)
<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other			
HEALTH CARD #	VERSION CODE (VC)	WSIB CLAIM #	OTHER (Self-pay, research, 3rd party payor)	
<input type="checkbox"/> INTERPRETER REQUIRED Preferred language		ACCESSIBILITY CONCERNS OR REQUIREMENTS		
ALTERNATE CONTACT (If not patient)	CONTACT NAME		CONTACT PHONE #	

EXAM INFORMATION AND HISTORY	
TEST/REGION(S) TO BE EXAMINED	REASON FOR EXAM / CLINICAL HISTORY (Please also include presenting symptom(s), relevant underlying diagnosis and therapies, where applicable)
<input type="checkbox"/> TIMED FOLLOW UP DATE REQUESTED (YYYY/MM/DD) <i>MRI availability is limited; requested dates will be accommodated where possible.</i>	

SCREENING AND PRECAUTIONS	
RENAL ASSESSMENT Impaired renal function? <input type="checkbox"/> Yes <input type="checkbox"/> No On dialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No If the answer to any of the above question(s) is yes, then please provide the most recent eGFR results (within the past 6 months) eGFR RESULT (ml/min/1.73 ²) DATE COLLECTED (YYYY/MM/DD) <input type="checkbox"/> Known hypersensitivity to contrast agents <input type="checkbox"/> Currently pregnant <input type="checkbox"/> Currently breastfeeding <input type="checkbox"/> Patient cannot provide reliable medical history or provide consent to contrast injections where applicable <input type="checkbox"/> Requires general anesthesia Rationale: <i>For patients with claustrophobia requiring oral sedation, the referring provider is responsible for prescribing the medications. Patients taking oral sedation must not drive and should arrange alternative transportation.</i>	POSSIBLE MRI CONTRAINDICATIONS <input type="checkbox"/> Has metal fragments in eye(s)/body <input type="checkbox"/> Cardiac pacemaker or defibrillator <input type="checkbox"/> Eye surgery/injury (excl. lens implants, cataract, or laser surgery) <input type="checkbox"/> Ear surgery/implant <input type="checkbox"/> Implanted stimulators or electrodes <input type="checkbox"/> Any filters, stents, coils, grafts, valves or programmable shunts <input type="checkbox"/> Aneurysm surgery/clips <input type="checkbox"/> Surgery within the last six (6) weeks <input type="checkbox"/> None of the above Please provide operative report and specify the device information below (include as much detail as possible): MAKE MODEL # INSTITUTION WHERE TREATMENT WAS RECEIVED

REFERRING PROVIDER			
PROVIDER NAME		BILLING #	PROFESSIONAL ID
ADDRESS		CITY	PROVINCE POSTAL CODE
PHONE #	FAX #	COPY TO	
PROVIDER SIGNATURE			DATE

HOSPITAL LOCATION – MUST BE SELECTED			
Select the hospital you would send this patient to, given their diagnostic imaging requirements. Patient will be directed to reasonable nearest hospital with lowest wait times:			
<input type="checkbox"/> Alexandra Marine and General Hospital	<input type="checkbox"/> Guelph General Hospital	<input type="checkbox"/> London Health Sciences Centre	<input type="checkbox"/> Strathroy Middlesex General Hospital
<input type="checkbox"/> Bluewater Health	<input type="checkbox"/> Haldimand War Memorial Hospital	<input type="checkbox"/> Niagara Health System	<input type="checkbox"/> Tillsonburg District Memorial Hospital
<input type="checkbox"/> Brant Community Healthcare System	<input type="checkbox"/> Hamilton Health Sciences	<input type="checkbox"/> Norfolk General Hospital	<input type="checkbox"/> Waterloo Regional Health Network
<input type="checkbox"/> Brightshores Health System	<input type="checkbox"/> Hanover and District Hospital	<input type="checkbox"/> South Bruce Grey Health Centre	<input type="checkbox"/> Wellington Health Care Alliance
<input type="checkbox"/> Cambridge Memorial Hospital	<input type="checkbox"/> Huron Perth Healthcare Alliance	<input type="checkbox"/> St Joseph's Health Care - London	<input type="checkbox"/> Windsor Regional Hospital
<input type="checkbox"/> Chatham-Kent Health Alliance	<input type="checkbox"/> Joseph Brant Hospital	<input type="checkbox"/> St Joseph's Healthcare – Hamilton	<input type="checkbox"/> Woodstock Hospital
<input type="checkbox"/> Erie Shores Healthcare	<input type="checkbox"/> Listowel Wingham Hospital Alliance	<input type="checkbox"/> St Thomas-Elgin General Hospital	
<input type="checkbox"/> Patient must go to selected hospital. This may result in longer wait times.			

OFFICE USE ONLY			
PRIORITY <input type="checkbox"/> P1 <input type="checkbox"/> P2 <input type="checkbox"/> P3 <input type="checkbox"/> P4	TIMED <input type="checkbox"/> YES <input type="checkbox"/> NO	SPECIFIED DATE	
CCO	PROTOCOL	RADIOLOGIST	