Ottawa and Eastern Ontario
Fax to Central Intake: 1 (613) 737-8944

Out-Patient MRI Requisition Form
Tel: 1 (613) 737-8883

Fields marked (*) must be completed to avoid delays in processing the referral.

Patient Information

*Last name	*First name	Middle name	*Date of birth (yyyy/mm/dd)

*Street address	*City	*Province	*Postal Code	Day tel. no.
				( ) ext.:

Preferred language	*Weight	*Height	Sex	Evening tel. no.
❑ English ❑ French ❑ Other:				( ) ext.:

Patient email	Patient consents to appointment information being disclosed to them by e-mail ❑ Yes ❑ No	Mobility Requirements ❑ Lift ❑ Wheelchair ❑ Stretcher

*Bill to:	*Insurance: Health card number	Province	Other Insurance or Payor Information
❑ OHIP ❑ DND ❑ Other:			

WSIB: Date of injury (yyyy/mm/dd)	Employer	Claim number

Exam Information and History

*Examination requested: (checklist **must** accompany referrals for headache or low back pain)	General anesthesia required: ❑ Yes ❑ No

*Patient history and clinical information: (include date & location of relevant previous exams)	*Known allergies:

Request for date specific exam:
Access to MRI services is limited and only some date requests will be met.
Specific date requested (yyyy/mm/dd): _____

Please justify clinical necessity of date:

Yes	No	*Please indicate the following:
❑	❑	Patient is pregnant
❑	❑	Patient is on dialysis
❑	❑	Patient has an allergy to MRI contrast agent

Yes	No	*Possible MRI Contraindications:
❑	❑	Intraocular lens implant/Prior metal fragment
❑	❑	Eye surgery (excl. lens implants, cataract or laser surgery)
❑	❑	Ear surgery (excl. ear tubes)
❑	❑	Cardiac pacemaker or defibrillator
❑	❑	Implanted stimulators or electrodes
❑	❑	Any filters, stents, coils, grafts or shunts
❑	❑	Aneurysm surgery

Preferred MRI site(s): Indicating a preference for a specific site may result in a longer wait time.	If available, please provide the value and date of the most recent eGFR result (within the last 3 months): **eGFR level:** **Date of test:**	*Please forward operative report and specify the device information below: ***Device:** ***Date:** ***Institution where treatment was received**

Hôpital Montfort is Ontario's Francophone academic hospital and the only hospital in the region guaranteeing services in French throughout the hospital. Cornwall Community Hospital and The Ottawa Hospital's General Campus are also designated under the French Language Services Act for most services in diagnostic imaging.

Referring Physician

*Last name	*First name	*Signature	
Address	City	Province	Postal Code
*Telephone no.	*Fax no.	*Billing no.	

Copy to

*Last name	*First name	*Fax no.	
Address	City	Province	Postal Code

Office Use Only

Protocol:

IV contrast	Priority Code	Protocoled by	eGFR required?	Appointment Date	Time
❑ Yes ❑ No			❑ Yes ❑ No ❑ 1m ❑ 3m ❑ 6m		