Trillium Health Partners

Credit Valley Hospital
2200 Eglinton Avenue W, Mississauga, ON L5M 2N1

MRI REFERRAL REQUEST

Tel - (905) 813 4179 Fax - (905) 813 4172

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

Redirect to:
☐ **THC**
☐ **HHS Oakville**
☐ **Any if waitlist is shorter**

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: MD Name

ADDRESS: _____

_____ POSTAL CODE: _____

P ( ) _____

F ( ) _____

COPIES TO: _____

OTHER RELEVANT TESTS & RESULTS

MRI: _____

CT/ANGIO: _____

X-RAY: _____

US: _____

2790 D (September/2013)

RESET