***NOTE: *Incomplete and / or unsigned requisitions will be returned!*

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

CT/MRI Requisition
Diagnostic Imaging Department

Markham Site Booking Line: (905) 472-7020 Fax: (905) 472-7078
Uxbridge Site Booking Line: (905) 852-9771 Fax: (905) 852-2465

Appointment Date & Time: ____________________

Hospital MRN #: ____________________
Patient Name: ____________________
Last First
Date of Birth: ____________________ **Sex: F M**
Day Month Year
Health Card # ____________________ **Version Code:** ________
Telephone # Home: ____________________
Other Telephone #: ____________________

Date:	Referring MD	Signature	MD Phone #

Additional Reports to:

Exam Requested ☐ **CT** ☐ **MRI**
Please check one only
Body Part: ____________________

Clinical Information:

Please attach previous imaging reports

Does the patient require sedation for Claustrophobia
☐ Yes (to be provided by referring Physician)
☐ No

Risks for Contrast Nephropathy/ Nephrogenic Systemic Fibrosis (MRI)	**YES**	**NO**
On Metaformin, Glucophage, or other generic brands	☐	☐
On Dialysis	☐	☐
Elderly (greater than 70 years of age)	☐	☐
Dehydration	☐	☐
Nephrotoxic medications	☐	☐
CHF	☐	☐
Solitary kidney	☐	☐
Multiple myloma	☐	☐
Is the patient pregnant?	☐	☐

Patient weight ____________________

If any risk factors for Contrast Nephropathy are present, you must provide the following:
Creatinine __________ B.U.N. ____________________

Date of blood test ____________________
Creatinine clearance __________ or eGFR __________

	YES	**NO**
Allergy to IV contrast media?	☐	☐
Is patient pre-medicated?	☐	☐

If YES please state:

Cardiac CT patients only:	**YES**	**NO**
Irregular Heartbeat/Palpitations	☐	☐
Pacemaker	☐	☐
Asthma	☐	☐
On Viagra / other E.D. medications	☐	☐

Radiologist Use Only ☐ P1 ☐ P2 ☐ P3 ☐ P4
Is this a specified date procedure ☐ YES ☐ NO
Exam Protocol
Clinical Indication for scan:
☐ Cancer staging and/or diagnosis
☐ Other ____________________

Radiologist initials ____________

****** PATIENT SCREENING MRI ONLY******

Please check Yes or No	**YES**	**NO**
1. Have you ever had an injury from a metal object in your eye which required medical attention?	☐	☐

If Yes, was it completely removed?
Please Provide details:

Referring Physician:

If YES to the above question, please order an x-ray of the orbits on your patient and submit the report with this requisition.

2. Do you have any of the following? * = an absolute contraindication		
* Cardiac pacemaker/Leeds/defibrillator	☐	☐
* Aneurysym clips	☐	☐
Cochlear implants	☐	☐
Neurostimulator/Implant pump	☐	☐
Shrapnel/Bullets	☐	☐
Other implants devices/Stents	☐	☐

3 Have you ever had surgery on your:		
Head/Eyes	☐	☐
Neck	☐	☐
Spine	☐	☐
Chest/Heart	☐	☐
Abdomen	☐	☐
Arms/Legs	☐	☐

If YES to any part of section 2 or 3 please provide details:

Booking Process

The Booking Department will notify either yourself or your referring Physician of your appointment date and time. MRI and CT appointments are in high demand; please ensure you inform us within 24 hours of your appointment if you cannot attend. This supports the Ministry of Health's wait time management program.

Children 10 years and under can not be left unattended in the waiting area and are not able to accompany patient into the exam room.

To cancel or rebook your appointments at Markham Stouffville Hospital please call:
905-472-7020 Monday to Friday between 8.30am and 4.30pm.

To cancel or rebook your appointments at Uxbridge cottage Hospital Site please call:
905-852-9771 ext 5249

If you require a translator please have them accompany you to your appointment to ensure we have accurate information and are able to answer all questions with you.

MRI PATIENT INFORMATION / PREPARATION

You will be asked to complete a patient screening form when you arrive.
Please leave any valuables at home, as the hospital is not responsible for any lost or stolen items. A locker will be provided to you for your other belongings.
If you wear clothing that does not have metal zippers, buttons, snaps or clasps you will not be required to change into a hospital gown. Hospital gowns will otherwise be provided.

For patients requiring sedation for Claustrophobia

Your physician will provide a prescription for you, please fill it before you arrive for your MRI appointment and take as directed by the physician. A responsible adult MUST drive you to and from you appointment.

For MRI and MRA of the Abdomen and Pelvis

Nothing to eat or drink 6 hours prior to your appointment time, except to swallow any necessary medication.

CT PATIENT INFORMATION / PREPARATION

CT scan of the Abdomen

Nothing to eat or drink 4 hours prior to your appointment.

CT Renal Colic

Drink 2 full 8 oz glasses of water one hour before your appointment. DO NOT EMPTY YOUR BLADDER.

All CT exams with contrast

Nothing to eat or drink 4 hours prior to your appointment.

FOR BOTH MRI AND CT APPOINTMENTS

Depending on your examination you may be required to drink a fluid that enhances your internal organs or you may have a contrast injection. Please be prepared to answer questions about your general health and inform us of any allergies you may have. The Technologist will let you know once you arrive at your appointment, if you will need either of the above.

Our booking staff will advise you or your doctor of any further preparatioon required before your appointment.

Address:

Markham Stouffville Hospital, 381 Church Street. Markham ON. L3P 7P3
Uxbridge cottage Hospital Site, 4 Campbell Drive, Uxbridge ON. L9P 1S4

Visit: www.msh.on.ca