Ontario
South West Local Health Integration Network

Choosing Wisely Canada

MRI REQUISITION – this form can be found on www.swpca.ca Check one Site:

☐ Grey Bruce Health Services - Owen Sound	F: 519-376-3952	☐ LHSC – VH / Children's	F: 519-667-6826
☐ Huron Perth Health Care Alliance - Stratford	F: 519-272-8247	☐ St. Joseph's Health Care London	F: 519-646-6025
☐ LHSC - UH	F: 519-663-3544	☐ Woodstock Hospital	F: 519-421-4238

PATIENT INFORMATION:

Surname: ____________ First Name: ____________ Middle Initial: ______

Gender: ☐ M ☐ F ☐ X Date of Birth (YYYY-MM-DD): ____________

Street Address: ____________ Apt: ____ City: ____________ Province: ______ Postal Code: ______

Health Card No. : ____________ Version Code: ______ Research or 3rd Party No.: ____________

Telephone (Day): ________ (Evening): ________ (Cell): ________

☐ Outpatient ☐ Long Term Care ☐ Inpatient ☐ ED

WSIB: ☐ Y ☐ N ______ WSIB No.: ________ Date of Injury (YYYY-MM-DD): ________

Mobility: ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Mechanical Lift Preferred Language: ☐ EN ☐ OTHER ________

Y N Please check the following:

- ☐ ☐ Breast feeding
- ☐ ☐ History of cancer
- ☐ ☐ Medication patch (Foil)
- ☐ ☐ Piercings (Remove prior to exam)
- ☐ ☐ Pregnant __ wks.
- ☐ ☐ Shrapnel or bullets
- ☐ ☐ Surgery in last 6 wks.
- ☐ ☐ Tattoos

Precautions:

☐ TB ☐ MRSA

☐ VRE ☐ Shingles

Y N Contrast Risk Factors

- ☐ ☐ Diabetic
- ☐ ☐ Hypertension
- ☐ ☐ Impaired renal function
- ☐ ☐ MRI contrast reaction
- ☐ ☐ On dialysis
- ☐ ☐ Gout
- ☐ ☐ Protein in Urine
- ☐ ☐ Kidney Surgery

____

If one or more of the above is Y provide serum creatinine result within last 6 months:

____

YYYY-MM-DD

Y N Possible MRI Contraindications

- ☐ ☐ History of Metal in Eye (*X-ray may be required)*
- ☐ ☐ Aneurysm surgery*
- ☐ ☐ **Cardiac pacemaker or defibrillator***
- ☐ ☐ Cochlear or Ocular Implants*
- ☐ ☐ Coils, filters, grafts, stents *
- ☐ ☐ Electronic devices, implanted or not implanted*
- ☐ ☐ Heart valve*
- ☐ ☐ Implanted stimulators, electrodes or pumps*
- ☐ ☐ Shunts: ☐ Programmable* ☐ Non-Programmable*
- ☐ ☐ Other: ____________

*Please forward surgical report and specify the:

Make/Model: ____________ **Date:** ____________

Institution of surgery: ____________

☐ Y ☐ N Surgery in exam area ☐ Y ☐ N Timed ☐ Y ☐ N Relevant reports attached **HEIGHT** ____ **CM/FT WEIGHT** ___ **KG/LBS**

REFERRING PHYSICIAN:

Last Name: ____________ First Name: ____________ **Signature:** ____________

Address: ____________ City: ____________ Province: ______ Postal Code: ______

Telephone: ________ Fax: ________ Billing No.: ________

COPY TO: ____________

EXAMINATION REQUESTED: ____________ **Working Diagnosis:** ____________

CLINICAL INFORMATION: ☐ Y ☐ N Recent trauma

Considerations: ☐ Claustrophobia ☐ Mild Sedation (not provided) ☐ General Anaesthesia ☐ Paediatric ☐ Interpreter Required

OFFICE USE ONLY

Protocol:

☐ P1 ☐ P2 ☐ P3 ☐ P4 ☐ Timed ☐ Contrast

X-rays required: ☐ Y ☐ N Staff Initials: ______

Appointment Date and Time: ____________

☐ Prep: NPO 4 hours prior to arrival

☐ No prep

NOTE: This requisition may be booked at an alternate site in the South West LHIN to improve patient access.

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MRI KNEE APPROPRIATENESS CHECKLIST

Patient label placed here, or minimum information below required

This checklist is required for all outpatient MRI knee referrals.
Please include with MRI requisition.

Referring Physician Name: ______________________________

Patient Name:
Date:
Date of Birth (YYYYMMDD):
Gender:
MRN/HCN:

CHECK ANY/ALL THAT APPLY:

A. ☐ Recent Knee X-rays Recommended For All Patients

Required for: Patients ≥ *55 years old*
Suspected *osteoarthritis* (weight bearing views)
History of *trauma*

B. ☐ Other Knee Imaging

What: ______________________________

When: ______________________________

Where: ______________________________

C. MRI *is* recommended for:

Locked knee/Mechanical symptoms (unable to fully extend knee with relaxed muscles)
Suspected ligamentous injury

Which ligament(s):
Persistent swelling/effusion despite conservative therapy for 4-6 weeks
Suspected soft tissue or bone tumour

D. MRI *is NOT* recommended if there is:

Moderate or severe osteoarthritis without locking or extension block
MRI is unlikely to alter patient management

E. Consider MRI if *all* of the following are present:

Absent or mild osteoarthritis
Persistent unexplained pain > 3 months
Failed conservative therapy (physiotherapy and anti-inflammatories)
Patient is surgical/arthroscopy candidate

F. Additional Clinical Information

Please provide any additional information relevant to this request.
Include arthroscopic and surgical reports.

______________________________ ______________________________
Referring Physician Signature Date