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 SPINE APPROPRIATENESS CHECKLIST

*This checklist is based on the Choosing Wisely criteria and the CORE Back Tool. It is required for all adult (18+) outpatient MRI spine referrals. **Please include with MRI requisition**.*

*Patient label placed here, or minimum information below required*

**Patient Name:** ______________________
**Date (YYYY-MM-DD):** ______________________
**Date of Birth (YYYY-MM-DD):** ______________________
**Gender:** ☐ M ☐ F ☐ X
**Health Card #:** ______________________

**Referring Physician Name:** ______________________

| **A. Red Flags requiring Emergent Management (immediate MRI and consultation to Surgery)** *(consider sending patient to Emergency Department)* | | |
|---|---|---|
| ☐ Severe/Progressive Neurologic Deficit | ☐ Cord Compression or Cauda Equina Syndrome | |
| **B. Red Flags requiring Urgent MRI** | | |
| ☐ Suspected Cancer | ☐ Suspected Spinal Infection | ☐ Suspected Epidural Abscess or Hematoma |
| ☐ Suspected Fracture *(recommend X-ray or CT first)* | | |
| **C. Mechanical Spine Pain Syndrome with no Red Flags requiring Non-Urgent MRI** *(Check all that apply – there MUST be a check in sections 1, 2, and 3 below to meet imaging criteria)* | | |
| **1.** ☐ Unbearable Arm or Leg Dominant Pain *(and/or)* | ☐ Disabling Neurogenic Claudication *(and/or)* | ☐ Functionally Significant Neurologic Deficit |
| **2.** ☐ Failure to Respond after 6 weeks of conservative care | **3.** ☐ Considering Surgery | |
| **D. Suspected or Known Conditions** *(Check all that apply)* | | |
| ☐ Cancer *(please specify)* | ☐ Intradural Tumour | ☐ Bone Tumour or Metastases |
| ☐ Congenital Spine Anomaly | ☐ Scoliosis | ☐ Spinal Radiation |
| ☐ Demyelination or MS | ☐ Inflammatory Disease | ☐ Assessment for Vertebroplasty |
| ☐ Prior Spine Surgery *(date)* | ☐ Arachnoiditis | ☐ Post-operative Collections |
| ☐ Follow-up for a Known Condition *(please specify)* | | |
| ☐ Condition Not Listed *(please specify)* | | |

**Prior CT or MRI Spine Imaging (Select one)**

☐ CT ☐ MRI
When: ______________________ Where: ______________________

## Additional Clinical Information

Please provide any additional information below. Please also clearly indicate the affected area on the image to the right.