St. Michael's
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Inspiring Science.

MedCentra MRI ASAP

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

Patient ID

MRI REQUISITION FORM

Get forms at www.MedCentra.com

Phone: 416-923-4567 **Fax completed form to 416-630-4674 (4MRI)**

Patient Name: (Please Print)		DOB: (D/M/Y)	MRN:
Address:		☐ Male ☐ Female	Weight: (Kg)
Health Card No: VC:	Home Tel:		Mobile/Work Tel:
Physician Name: (Please Print)		CC Copies To:	
Phys Tel:	Phys Fax:	Phys Billing #:	

Area to be Scanned: (Please be specific) _____

Clinical Information:

The following can interfere with the MR Imaging and/or can be a safety hazard. If the following information changes between now and the appointment notify the MRI Department. **Inaccurate information can result in appointment cancellation the day of exam.**

	Yes	No		Yes	No
1. Has the patient ever had an MRI?			6. Is the patient diabetic?		
2. Has the patient ever had a penetrating eye injury which required a metal fragment/object to be removed by a physician?			7. Does the patient have a history of kidney dysfunction or have a single kidney?		
3a. Has the patient worked with metal (professionally or hobby) as a welder, metal grinder or metal cutter?			8. Is the patient over the age of 70?		
3b. If yes, since the previous MRI? (If applicable)			9. Is the patient claustrophobic? Sedation must be brought with the patient and he/she must have an accompanying escort. MRI will not prescribe nor dispense.		
3c. If yes, was eye protection always worn?			10a. Will the patient require an interpreter? 10b. If yes, for which language? _____		
4. Is the patient pregnant or breastfeeding?					

5. Indicate if the patient has the following:	Yes	No		Yes	No
Cardiac pacemaker or pacing wires (epicardial)			Artificial heart valve		
Implanted defibrillator (ICD)			Breast tissue expander		
Neurostimulator/TENS unit			Penile implant		
Cochlear (middle ear) implant			Shrapnel, bullet, BB pellet foreign body		
Brain aneurysm clip			Drug infusion pump		
Intravascular stent, filter, coil			Other metallic implants?		

List all previous surgeries and implants:

Include date and location of the surgery to ensure compatibility. Implant serial numbers may be requested.

I attest that the contents of this form are verified and the procedure has been explained to the patient including the possibility of the use of contrast agents.

Physician's Signature: _____ **Date:** _____

Incomplete and/or illegible forms will be returned resulting in a delay of appointment booking.

For MRI Dept App't Date: App't Time: Scanner:

Form No. 69240 Dev. 03/16/2011 Rev. 09/13/2012

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THIRD PARTY PAYOR INFORMATION FORM

Tel: 416-923-4567 • **Fax:** 416-630-4674 (4MRI)

AUTO INSURANCE COMPANY:

Company name _____Contact Person _____

Address _____

Phone # _____Fax # _____

E-Mail _____Policy # _____

Claim # _____Date of accident _____

WSIB:

Claim # _____

Nurse Consultant / Adjudicator _____

Date of accident_____

Memo # _____

LAW FIRM/LAWYER:

Firm / Lawyer Name _____Contact Person _____

Address _____

Phone # _____Fax # _____

E-Mail _____Client / File # _____

Method of Payment_____

OTHER THIRD PARTY PAYOR (E.G., EMPLOYER, OTHER INSURANCE COMPANY):

Payor Name _____Contact Person _____

Address _____

Phone # _____Fax # _____

E-Mail _____ID # _____

Method of Payment_____

I hereby authorize St. Michael's Hospital and/or Markham Stouffville Hospital to release, by any means including email or fax, information and records related to my medical examination to the referring physician, to MedCentra Inc. and/or to the above-noted third party payor (the "Payor"), and/or to any other person or entity for any purpose related to the provisions of the *Insurance Act*, the *Workplace Safety and Insurance Act*, the *Health Insurance Act* and/or any Regulation thereto (including the *Statutory Accident Benefits Schedule*). I acknowledge that the Payor will be liable for the payment of the fees charged for my medical examination, but in the event the Payor fails to pay such fees to MedCentra Inc. within 30 days of receiving an invoice therefor, then I may be liable, jointly and severally with the Payor, for the payment of such fees to MedCentra Inc. I also acknowledge that the Payor will be invoiced for the full fees that would be charged for my examination in the event that I do not / did not attend a scheduled appointment without 24 hours' notice of cancellation.

TO BE SIGNED BY THE PATIENT _____

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DECLARATION OF NON-OHIP/ THIRD PARTY ELIGIBILITY

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CHECK OFF THE APPROPRIATE CATEGORY APPLICABLE TO THE PATIENT:

- ***AUTOMOBILE INSURANCE:*** Auto insurance policies are specifically excluded from the general prohibition against contracts of insurance for the payment of the costs of services insured by OHIP. All auto insurance policies provide for certain "medical benefits" including all reasonable and necessary expenses for medical and hospital services, and any related assessments or examinations, incurred by an insured person as a result of an automobile accident.

- ***WSIB:*** Services that a person is entitled to receive under the insurance plan established pursuant to the *Workplace Safety and Insurance Act* are not services insured by OHIP. A worker who sustains a personal injury by accident arising out of and in the course of his employment is entitled to such health care (including services provided by a physician/hospital) as may be necessary, appropriate and sufficient as a result of the injury, with the costs of such health care to be paid by the Workplace Safety and Insurance Board.

- ***THIRD PARTY SERVICES:*** A "third party service" is a service that is provided to a person by a physician, hospital or other service provider in connection with a request or requirement, made by a third party, that the service be provided to the person, or that information relating to the person be provided to the third party. The third party that makes the request or requirement is liable for payment to the service provider for the service provided to the person. Specified third party services that are not insured by OHIP are those which are received wholly or partly for the production of a document, or the transmission of information to the third party, if the document or the information relates to:

    - admission to/continued attendance in a school/educational program
    - admission to/continued attendance in a recreational/athletic club/program
    - an application for/continuation of insurance
    - an application for/continuation of a license
    - entering/maintaining a contract
    - an entitlement to benefits, including insurance or pension benefits
    - obtaining/continuing employment
    - an absence from/return to work
    - legal requirements/proceedings

- ***OTHER NON-OHIP:*** Some health care services are otherwise excluded from services insured by OHIP under provincial regulations (e.g. exam not meeting specific OHIP criteria for particular body part, exam in support of treatment considered experimental, exam for purpose of clinical research, etc.)

- ***NON-RESIDENT:*** Only persons who are ordinarily resident in Ontario, as well as certain other persons deemed to be residents under provincial regulations, are entitled to receive OHIP-insured services without charge. Therefore, services provided to non-residents of Ontario are not insured by OHIP.

The patient, referring physician/physician's agent and/or third party/third party's agent (if applicable) hereby certify that the patient meets all of the requirements of the category checked above.

Patient Signature _____

Physician/Agent Signature _____

Third Party/Agent Signature _____