Leading with Innovation
Serving with Compassion

ST. MICHAEL'S HOSPITAL
A teaching hospital affiliated with the University of Toronto

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

MedCentra MRI ASAP

Request for MRI Examination

Phone: (416) 630-4MRI (4674)
Fax: (905) 494-0746
Get Forms @ www.MedCentra.com

Appointment Date & Time

Patient ID

Patient Information:

SMH Med. Rec.No:_____ Sex: ☐ M ☐ F

Name: _____ D.O.B. _____

Address: _____

Province: _____ Postal code: _____

Telephone: Home _____Business _____

Cell Phone: _____

Date of Accident/Injury: _____

WSIB Claim No.:_____
OR
Insurance Claim No.:_____Policy No.: _____

Referring Physician Information:

Name: _____

Address: _____

City: _____

Province: _____

Postal Code: _____

telephone No: _____

Fax No: _____

Email: _____

Physician's Signature: _____

Area to be scanned: *(Please be specific)* _____

Clinical Information: _____

_____

Working Diagnosis: _____

Differential Diagnosis: _____

Prolactin Level (for MRI Pituitary Gland): _____

Test Already Performed:

☐ MRI ☐ X-ray ☐ CT ☐ Myelogram ☐ Angiogram ☐ Nuclear Medicine ☐ Ultrasound

☐ Other *(specify)* _____

Date and Results:

Please attach any relevant report and forward any recent films.

OFFICE USE ONLY:

Exam Date: _____ Time: _____ Scanner: _____

Imaging Protocol:

Radiologist: _____ Technologist: _____ # Films: _____

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Medical Imaging

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Patient ID

Patient Screening Information

1. Have you ever worked with metal? ◯ Yes ◯ No
2. Has metal ever gone into your eye? ◯ Yes ◯ No
3. Could you be pregnant? ◯ Yes ◯ No
4. Do you have any of the following?
   - Cardiac Pacemaker ◯ Yes ◯ No
   - Artificial Cardiac Valve ◯ Yes ◯ No

     Type: _____ Model: _____
   - Aneurysm Clips ◯ Yes ◯ No

     Type: _____ Date of Surgery: _____
   - Neurostimulator ◯ Yes ◯ No
   - Cochlear Implants ◯ Yes ◯ No
   - Shrapnel/Bullets ◯ Yes ◯ No

     Location: _____
   - Porta Cath/Vascular Acess Port ◯ Yes ◯ No
   - Swan-Ganz Catheter ◯ Yes ◯ No
   - Intravascular Coil/Filter or Stent ◯ Yes ◯ No
   - Dentures/Braces/Retainer ◯ Yes ◯ No
   - Hearing Aid ◯ Yes ◯ No
   - Other implanted device ◯ Yes ◯ No

     Please specify: _____
5. Have you ever had surgery on your?

   ☐ Head ☐ Neck ☐ Spine
   ☐ Chest ☐ Abdomen ☐ Arms/Legs

   Please give details: _____
6. Are you claustrophobic? ◯ Yes ◯ No

   If Yes, please bring medication with you.
7. Do you require an interpreter? ◯ Yes ◯ No

   If Yes, what language? _____
8. What is your current weight? _____

Tech. Signature _____

Patient Signature _____

Patient Information for MRI
Only for Cervical, Thoracic and Lumbar Spines

1. What was your major complaint when you visited the doctor?

   _____
2. Describe your pain - i.e. burning, sharp, dull, etc.

   _____
3. Does the pain go down your arm or leg? _____
   In the front or back? _____
   Left, right or both? _____
4. Does anything make it worse - standing, sitting, lying down?

   _____
5. What do you think caused the problem?

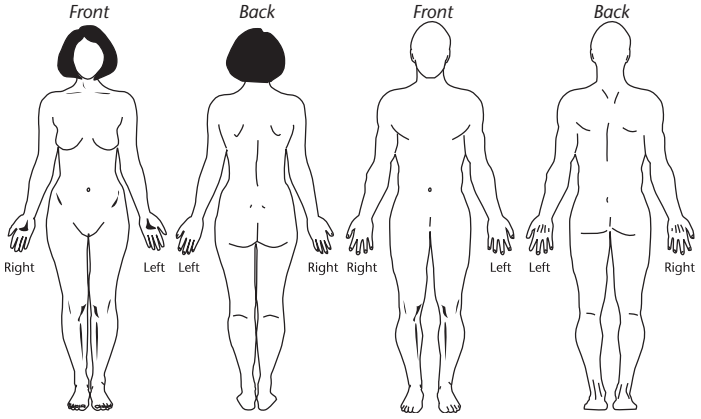
   _____
6. When you wake in the morning is your pain better or worse?

   _____
7. Do you have any numbness? _____
   Where _____
8. Do you have any weakness? _____
   Where _____
9. Have you had any bowel or bladder changes? _____
   Describe: _____
10. Have you had any spine surgery? _____
    When? _____
    What was done? _____
11. Do you have any other medical condition?

    _____
12. Describe your general health. _____

    _____

Please Shade Areas of Discomfort



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THIRD PARTY PAYOR INFORMATION FORM

Tel: (416) 630-4MRI (4674) • Fax: (905) 494-0746

AUTO INSURANCE COMPANY:

Company name _____ Contact Person _____

Address _____

Phone # _____ Fax # _____

E-Mail _____ Policy # _____

Claim # _____ Date of accident _____

WSIB:

Claim # _____

Worker's impairment _____

_____

Date of accident _____

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 to release 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 will 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:*** Automobile 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 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. "Health care" includes professional services provided by a physician or other health care practitioner, and services provided at hospitals and other health facilities.

☐ ***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

☐ ***NON-RESIDENTS:*** 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, medical services provided to non-residents in Ontario are not insured by OHIP.

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

Patient Signature _____

Referring Physician Signature _____

Third Party Signature _____