DIAGNOSTIC IMAGING: HISTORY AND PHYSICAL

The Hospital for Sick Children
555 University Avenue
Toronto, Ontario
M5G 1X8

(P) 416-813-5774 ext 3 (F) 416-813-5789

Name:
HSC#:
DOB:
Sex: ☐ M ☐ F
OHIP #:
Address:
City: Province:
Postal Code:
Telephone:
Parent/Guardian:

ADDRESSOGRAPH

This form is to be completed prior to booking the MRI by the referring physician. Please send with requisition to allow appointment to be booked appropriately.

Date of Examination:_____

Relevant History

1. Past Health_____
_____

2. Condition Requiring MRI_____
_____

Physical Examination

3. ENT & Airway: ☐ snoring ☐ drooling ☐ enlarged tonsils ☐ apnea
☐ blue spells ☐ GERD ☐ home O^2 therapy ☐ other_____

Chest: ☐ asthma ☐ reactive airway ☐ inhalers ☐ other_____

Cardiovascular: ☐ heart murmur ☐ ECG/ECHO reports

Cardiologist's name and number:_____

Musculo/Skeletal: ☐ hypotonia ☐ headlag ☐ cervical abnormalities ☐ other_____

Neurological: ☐ seizures

Additional Medical Notes_____
_____

Specific Requirements

Please provide details pertaining to the following medical issues:

4. Was the child a premature baby? ☐ yes ☐ no
If yes, how many weeks?

5. Is the child diabetic? ☐ yes ☐ no

6. If the patient is of Caribbean/African descent, they must be tested for Sickle Cell. Results are to be submitted with requisition.

7. If patient in under 6 months of age, recent Hbg must be submitted with requisition.

Completed by: Physician's name:_____ Signature:_____ Date_____

Incomplete forms will be returned to you for completion, resulting in a delay obtaining an appointment.