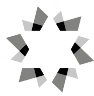

Mount Sinai Hospital
Sinai Health System
Joseph & Wolf Lebovic Health Complex

Medical Imaging Request Form

600 University Avenue
Toronto, Ontario, Canada M5G 1X5
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Clearly imprint patient identification card

All patients to provide their Provincial Health Coverage Card or Payor Information day of appointment.

✔	Modality ALL AREAS ARE SCENT FREE	Floor or Location	Telephone	Fax
☐	X-Ray (General Imaging)	5th floor	416-586-4411	416-586-8866
☐	Angiography, Gastrointestinal, Interventional	5th floor	416-586-4800, ext. 4418	416-586-3180
☐	Breast Imaging (Mammography & Breast Ultrasound)	Marvelle Koffler Breast Centre, 12th floor	416-586-4422	416-586-4714
☐	Nuclear Medicine	6th floor, Room 6-201	416-586-4446	416-586-8790
☐	Ultrasound	5th floor	416-586-4450	416-586-1569
	For Obstetric Ultrasound use the CEOU *(Centre of Excellence in Obstetric Ultrasound)* request form	Ontario Power Generation Building 700 University Avenue, 3rd floor	416-586-8556	416-586-8405
	For MRI use the *Magnetic Resonance Imaging* request form	5th floor	416-586-4941	416-586-4797
	For CT use the *Computed Tomography Imaging* request form	5th floor	416-586-4800, ext. 4418	416-586-3180

PATIENT INFORMATION: INCOMPLETE REQUISITIONS WILL BE RETURNED

BIRTHDATE YYYY MM DD

HOSPITAL MEDICAL RECORD NO.

SURNAME

GIVEN NAME

ADDRESS (Street, Apt #)

CITY/TOWN

PROVINCE

POSTAL CODE

TELEPHONE (Area Code & No.)

Health Card Number

Version Code

Exam Requested

Date of Request Y Y Y Y M M D D

Clinical History and Indication

Allergies ☐ Yes ☐ No

If YES, specify

Diabetic ☐ Yes ☐ No

REFERRING PHYSICIAN INFORMATION

Name and Initials (Print):

Doctor's Signature: REQUIRED

Telephone #: ( )

Fax #: ( )

Requested Appointment Date (if applicable):

Billing & CPSO # REQUIRED

Mailing Address:

MEDICAL IMAGING USE ONLY

RADIOLOGIST SIGNATURE:	APPOINTMENT DATE (YYYY MM DD)	PROTOCOL:
RADIOLOGIST NAME (PRINT):	APPOINTMENT TIME (24 hr clock) (HH:MM)