Holland Bloorview
Kids Rehabilitation Hospital

Bloorview Research Institute
Telephone: (416) 425-6220
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Request for Research Magnetic Resonance Imaging (MRI)

Participant Information

First Name:_____Last Name:_____

DOB:(mmm/dd/yyyy):_____ Sex: M☐ F☐ Other☐

Height:_____ Weight:_____(max allowable weight 540 lbs and 60cm girth)

Address:_____

City:_____ Province:_____ Postal Code: _____

Home Tel. #:_____ Mobile #_____Work #_____

Mobility Status: Walking ☐ Wheelchair ☐

Will participant require a lift to lay supine? Y ☐ N ☐

Will participant be able to cooperate and lay still for up to 60 minutes? Y ☐ N ☐

Will participant require a translator? Y ☐ N ☐ Language: _____

Exam Requested

Study Name/ID #:_____

Principal Investigator (PI):_____

Contact Tel #._____ Email: _____

Participant ID #: _____Site ID #:_____

Area for scan (be specific):_____

Preliminary MRI Screening

Cardiac Pacemaker/ Defibrillator Y ☐ N ☐
Retained Pacing Wires Y ☐ N ☐
Aneurysm clips Y ☐ N ☐
Artificial Cardiac Valve Y ☐ N ☐
Intravascular coils, filter, clip, stent Y ☐ N ☐
Inner ear or hearing implant Y ☐ N ☐
Neuro/bio-stimulator Y ☐ N ☐
Ventriculoperitoneal (VP) shunt Y ☐ N ☐

Metal prosthesis (e.g. screws, pins, joint replacements, artificial limb Y ☐ N ☐
Insulin or infusion pump Y ☐ N ☐
Medication Patches Y ☐ N ☐
History of penetrating eye injury Y ☐ N ☐
Braces/ dental implant Y ☐ N ☐
Pregnant Y ☐ N ☐
Other Implants:

List all surgeries and approximate year of surgeries:

_____

_____

Form Completed by : _____ Role: _____

PI confirms the participant is consented for the study and this MRI scan: Y ☐ N ☐

Principal Investigator/ Delegate Signature:_____

Date: _____

Incomplete or illegible forms will be returned resulting in delay in scheduling appointments

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