MINDS
Mississauga Institute of Neurological Disorders and Stroke

Unit #9, 2145 Dunwin Drive
Mississauga, Ontario L5L 4L9

Phone: (905) 896-3000
Fax: (905) 896-8906
Website: www.mindsneurology.com

THIRD-PARTY MRI REQUISITION FORM

PATIENT INFORMATION

Last Name:	First Name:	Gender: □ Male □ Female
Date of Birth (DD/MM/YYYY):	Home #:	Cell #:
Health Card #:	□ Private Pay □ Motor Vehicle Accident □ Private Medical Insurance	

Does your patient have any of the following MRI safety risks? (Must be completed – especially kidney questions)	Yes	No
Possibility that you are pregnant		
Any injury ever to your eye(s) from a metal object		
Any injury every from a metal object (e.g. bullet, shrapnel)		
Cardiac pacemaker, implanted cardioverter defibrillator		
Intracranial aneurysm clips		
Surgical staples, surgical clips, metallic sutures		
Metallic filter, stents, coils, shunt		
Neuro/Bio-stimulator, drug infusion pump		
Electronically or magnetically activated device		
Vascular access port, catheter		
Artificial heart valve		
Tissue expander		
Orthopedic hardware (e.g. joint replacement)		
Prosthetic device (e.g. limb, penile, eye, ear)		
Intrauterine device, diaphragm, pessary		
Body art (e.g. tattoos, permanent makeup, body piercings)		
Dental appliance (e.g. dentures, braces, retainer, plates)		
Medication path (specify)		
Claustrophobia (referring doctor is responsible for sedation)		
Acute renal failure		
Chronic kidney disease		
On dialysis		
If yes, please indicate dialysis day(s) and time: □ **Mo** □ **Tu** □ **We** □ **Th** □ **Fr** **Time:** _____		

Supplementary information

Height: _____ cm **Weight:** _____ kg
Table weight limit is 300lbs

Transportation requirements
□ Ambulatory □ Wheelchair □ Other: _____

Creatinine: _____ µmol/L
Blood collection date (d/m/y): _____

Allergies: _____

Previous imaging (reports must be attached)
□ MRI □ CT scan □ X-ray
□ Ultrasound □ Angiogram □ Nuclear Medicine

Previous surgeries (reports must be attached)
□ Head/neck: _____
□ Spine: _____
□ Heart/chest: _____
□ Abdomen/pelvis: _____
□ Extremities: _____

Implant/Device details
Make _____ Model _____
Date implanted (d/m/y) _____
Make _____ Model _____
Date implanted (d/m/y) _____

Patient signature:

REFERRING PHYSICIAN INFORMATION

Name:	
Phone:	Fax:
Copies to:	

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THIRD-PARTY PAYOR INFORMATION FORM

Auto Insurance Company:

Company name:	Contact person:
Address:	
Phone #:	Fax #:
E-mail:	Policy #:
Claim #:	Date of the 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):

Company name:	Contact person:
Address:	
Phone #:	Fax #:
E-mail:	
Method of payment:	

I hereby authorize the MRI/CT facility to release, by any means including email or fax, information and records related to my medical examination to the referring physician, to Mississauga Institute of Neurological Disorders and Stroke (MINDS) 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 MINDS within 30 days of receiving an invoice there for, then I may be liable, jointly and severally with the Payor for the payment of such fees to MINDS. 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 48 hours' notice of cancellation.

TO BE SIGNED BY THE PATIENT: _____

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THIRD-PARTY PAYOR INFORMATION FORM

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.

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: _____

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THIRD-PARTY PAYOR WAIVER FORM

Attention:

We have received a referral form to schedule your affiliate, _____, for a Medical Imaging examination.

As you may be aware, Mississauga Institute of Neurological Disorders and Stroke (MINDS) provides access to diagnostic imaging examination services to third party payers. Individuals cannot pay for a Medical Imaging examination privately. We have implemented a policy whereby we are requesting that our third-party clients provide us with an assurance that they are paying for the Imaging examination of the Ontario resident they are sending to MINDS. In addition, it is understood that the corporation is paying for this service as an entitlement to a corporate health benefit.

As soon as we receive a fax or email of this completed form, we would be happy to assist you in booking the appointment for your client. We appreciate your assistance in this matter.

TO BE COMPLETED BY REPRESENTATIVE OF THIRD-PARTY PAYER

This will confirm that our affiliate, _____ is not paying for his/her Medical Imaging examination privately. The third party responsible for payment of this corporate benefit is:

_____

Name and full address of the company

_____ _____

Authorized Signature Name and Title (Print)

_____

Date

Please send this completed for by fax to (905) 896-8906 or scan and email to ime@mindsneurology.com
If you require assistance with completion of these forms, please contact (905) 896-3000.