St. Joseph's Hospital
Medical Imaging Program
268 Grosvenor St., P.O. Box 5777, Stn. B
London, ON N6A 4V2
Tel. (519) 646-6000 ext. 61376
Fax. (519) 646-6025

MRI of the Rectum – Clinical Information

Please complete the information below when ordering an MRI of the rectum for staging rectal carcinoma. This greatly facilitates the radiologist's interpretation.

Please fax this form, **with the completed St. Joseph's MRI requisition form**, to (519) 646-6025.

Patient Label or Patient Information:

First name: _____

Last name: _____

Date of Birth: _____
(YYYY-MMM-DD)

Referring physician: _____

Does the patient have biopsy-confirmed rectal carcinoma?

☐ **Yes** ☐ **No**

Clinical / endoscopic location of the tumour:

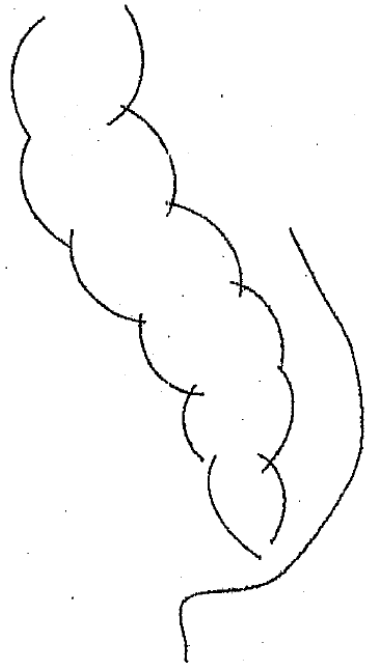
_____ **cm**

☐ **Low** ☐ **Mid** ☐ **High**

Histology:

☐ **Mucinous** ☐ **Non-mucinous**

****PLEASE INDICATE LOCATION OF TUMOUR ON DIAGRAM****



Sagittal View

Previous treatment:

☐ None

☐ Surgery Date of surgery: _____

Type of surgery: _____

☐ Chemotherapy Date of last cycle: _____

Additional pertinent clinical information: