

MAGNETIC RESONANCE IMAGING (MRI) REQUISITION

Last Name		First Name			Middle Initial
Address		City	Province	Postal Code	
Home Phone	Work Phone		PHN#	WCB/ICBC#	
Date of Birth	Gender	Weight	Known Allergies		Priority: <input type="checkbox"/> Routine <input type="checkbox"/> Semi-Urgent <input type="checkbox"/> STAT
DAY MONTH YEAR	<input type="checkbox"/> F <input type="checkbox"/> M	Kg			

SAFETY

Is the patient pregnant? (If YES, # of weeks: _____)	YES	NO
Is the patient a metal worker / had metal eye injuries? (If YES, orbital x-rays are required)	YES	NO
Does the patient have a Cardiac Pacemaker or Cardiac Defibrillator?	YES	NO
Does the patient have a Neuro or Bio Stimulator or Cochlear Implants?	YES	NO
Does the patient have Implanted Venous or Drug Infusion Device?	YES	NO
Does the patient have any other type of electronic, mechanical, or magnetic implants? If YES, specify type: _____	YES	NO
Is the patient Claustrophobic? (If YES, sedation must be arranged by treating doctor or UCC prior to appointment)	YES	NO

AREA/TYPE OF EXAMINATION

Brain:	<input type="checkbox"/> Routine (or with)	<input type="checkbox"/> IAC	<input type="checkbox"/> Sella	<input type="checkbox"/> MRA (circle of Willis)	<input type="checkbox"/> TBI
Spine:	<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracic	<input type="checkbox"/> Lumbosacral	<input type="checkbox"/> Coccyx	
Extremities:	<input type="checkbox"/> Knee L or R	<input type="checkbox"/> Wrist L or R	<input type="checkbox"/> Hip L or R	<input type="checkbox"/> Shoulder L or R	
	<input type="checkbox"/> MR Arthrogram	<input type="checkbox"/> Ankle L or R	<input type="checkbox"/> Elbow L or R		
Body:	<input type="checkbox"/> Liver	<input type="checkbox"/> Kidneys/Adrenal	<input type="checkbox"/> Pancreas	<input type="checkbox"/> MRV	<input type="checkbox"/> Full Body Screening <input type="checkbox"/> Inc. CT Chest, CT Calcium Score, Colonography <input type="checkbox"/> Inc. CT Chest, CT Calcium Score
	<input type="checkbox"/> Breasts	<input type="checkbox"/> Cardiac	<input type="checkbox"/> MRA™	<input type="checkbox"/> Pelvis	
	<input type="checkbox"/> (Bilateral)	<input type="checkbox"/> Other (specify) _____			

HISTORY

History and Clinical Diagnosis: <small>(Please include prior surgery, special instructions if any)</small>	List Previous Relevant Exams <small>(Please submit images & reports)</small>	Medication List:

PHYSICIAN INFORMATION

Referring Physician (please print): _____		
Referring Physician Signature (required): _____	Date: _____	
College License #: _____	Phone: _____	Fax: _____
Additional Copies: _____		

OFFICE USE ONLY

Date of Exam: <u>DAY</u> / <u>MONTH</u> / <u>YEAR</u> Time: _____	Gadolinium: YES NO	Buscopan: YES NO

