FALSE CREEK HEALTHCARE CENTRE

Centric Health Surgical Centre

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 (DAY / MONTH / YEAR)	Gender ☐ F ☐ M	Weight Kg	Known Allergies

Priority: ☐ Routine ☐ Semi-Urgent ☐ STAT

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?	YES	NO
If YES, specify type: _____		
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:	☐ Routine (or with)	☐ IAC	☐ Sella	☐ MRA (circle of Willis)	☐ TBI
Spine:	☐ Cervical	☐ Thoracic	☐ Lumbosacral	☐ Coccyx	
Extremities:	☐ Knee L or R	☐ Wrist L or R	☐ Hip L or R	☐ Shoulder L or R	
	☐ MR Arthrogram	☐ Ankle L or R	☐ Elbow L or R		
Body:	☐ Liver	☐ Kidneys/Adrenal	☐ Pancreas	☐ MRV	☐ Full Body Screening ☐ Inc. CT Chest, CT Calcium Score, Colonography ☐ Inc. CT Chest, CT Calcium Score
	☐ Breasts	☐ Cardiac	☐ MRA ™	☐ Pelvis	
	☐ (Bilateral)	☐ Other (specify) _____			

HISTORY

History and Clinical Diagnosis: (Please Include prior surgery, special instructions if any)	List Previous Relevant Exams (Please submit images & reports)	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: DAY MONTH YEAR Time: _____ Gadolinium: YES NO Buscopan: YES NO

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