Central Alberta
Medical Imaging Services

P: 403-755-1060 | F: 403-309-0093 | www.camiscare.ca
info@camiscare.ca

MRI REQUEST FORM

Appt Date/Time _____

PLEASE FAX A COPY OF THE REQUEST TO CENTRAL ALBERTA MEDICAL IMAGING SERVICES LTD. 403-309-0093

Patient Information

Name _____
Address _____
City _____
Province _____ Postal Code _____
Phone Home _____ Alt _____

DOB (D/M/Y) _____ M ☐ F ☐
A.H.C.# _____
WCB Claim # _____
Date of Injury (D/M/Y) _____

Clinical Information (Required) _____

Exam Requested _____

SEND ALL RELEVANT FILMS / REPORTS

For patient SAFETY the MRI Examination will NOT be booked unless this section is complete.

YES	NO	
☐	☐	Is the patient pregnant?
☐	☐	Is the patient claustrophobic?
☐	☐	Has the patient had cardiac or neurosurgery?
☐	☐	Cardiac pacemaker?
☐	☐	Aneurysm clip or surgery?
☐	☐	Neurostimulator?
☐	☐	Middle ear prosthesis?

YES	NO	
☐	☐	Has the patient **EVER** injured their eye with metal?
☐	☐	Did the patient seek medical attention for that injury?
☐	☐	Does the patient have renal disease?
☐	☐	Does the patient have compromised renal function?
☐	☐	Is the patient on dialysis?

Patient Weight: _____

Type, date and location of last surgical procdure: _____

_____

Referring Physician

Stat Report ☐

Name _____
Address _____
_____
Phone _____ Fax _____

PRAC ID _____
Signature _____
CC _____
_____ Fax _____