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) ______________________

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Exam Requested ______________________

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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: ______________________

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Referring Physician

Stat Report ☐

Name ______________________
Address ______________________
____
Phone ____________ Fax ____________

PRAC ID ______________________
Signature ______________________
CC ______________________
____________ Fax ____________