

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 _____ M F Other
 Address _____ DOB (D/M/Y) _____
 City _____ A.H.C.# _____
 Province _____ Postal Code _____ WCB Claim # _____
 Phone Home _____ Alt _____ 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 procedure: _____

Referring Physician

Stat Report

Name _____
 Address _____

 Phone _____ Fax _____

PRAC ID _____
 Signature _____
 CC _____
 _____ Fax _____