



CT/MRI REQUEST FORM (PRIVATE) 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)

<p>MRI (Private Pay)</p> <p><input type="checkbox"/> Brain _____</p> <p><input type="checkbox"/> TMJ</p> <p><input type="checkbox"/> Neck</p> <p><input type="checkbox"/> Full Spine <input type="checkbox"/> C spine <input type="checkbox"/> T spine <input type="checkbox"/> L spine</p> <p><input type="checkbox"/> Abdomen</p> <p><input type="checkbox"/> Pelvis</p> <p><input type="checkbox"/> Abdo/Pelvis <input type="checkbox"/> MSK Pelvis</p> <p><input type="checkbox"/> Joint / Extremity _____ <input type="checkbox"/> Arthrogram</p> <p><input type="checkbox"/> Prostate</p> <p><input type="checkbox"/> Chest Wall</p> <p><input type="checkbox"/> Cardiac</p> <p><input type="checkbox"/> Soft Tissue Mass Location: _____</p> <p><input type="checkbox"/> Whole Body Screen</p> <p><input type="checkbox"/> Other: _____</p>	<p>Screening Questionnaire</p> <p><input type="checkbox"/> Pregnant <input type="checkbox"/> Renal disease</p> <p><input type="checkbox"/> Claustrophobia <input type="checkbox"/> Dialysis</p> <p><input type="checkbox"/> Cardiac pacemaker <input type="checkbox"/> Middle ear prosthesis</p> <p><input type="checkbox"/> Cardiac or neurosurgery <input type="checkbox"/> Diabetic Monitor</p> <p><input type="checkbox"/> Neurotransmitter <input type="checkbox"/> Eye injury with metal</p> <p><input type="checkbox"/> Any implants in or on the body</p> <p><input type="checkbox"/> Aneurysm clip or embolization coil</p> <p>Weight: _____</p> <p>Type, date and location of last surgical procedure:</p> <p>_____</p> <p>_____</p> <p>_____</p>
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CT (Private Pay)

<input type="checkbox"/> Head	<input type="checkbox"/> Neck Soft Tissue	<input type="checkbox"/> Renal Colic
<input type="checkbox"/> Orbits	<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Pelvis
<input type="checkbox"/> Sinus	<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> Abdo Pelvis
<input type="checkbox"/> CTA-COW	<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/> Chest Abdo Pelvis
<input type="checkbox"/> CTA Neck	<input type="checkbox"/> SI Joints	<input type="checkbox"/> Pelvic Bones
<input type="checkbox"/> Temporal Bones	<input type="checkbox"/> Chest	<input type="checkbox"/> Joint Extremity
<input type="checkbox"/> Facial Bones	<input type="checkbox"/> Abdomen	
<input type="checkbox"/> Other _____		

Serum Creatine (within 90 days) _____ Date: _____
 GFR (within 90 days) _____ Date: _____

Referring Physician

Name _____
 Address _____
 Phone _____
 Fax _____

Stat Report

PRAC ID _____
 Signature _____
 CC _____
 Fax _____