

# 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 \_\_\_\_\_