



MRI Referral Form

This questionnaire is to be printed and completed by the physician and the patient and attached to the requisition before an MRI Exam can be scheduled.

Scheduling Phone Number: 1-866-MRI-EXAM (674-3926) **Fax Number:** 1-613-962-6136

First Name: _____ Last Name: _____

Date of Birth: D_____ M_____ Y_____ Weight: (lbs) _____

Physician: _____ Type of MRI: _____

Y N

Claustrophobic? _____

Do you work with metal? _____

Please indicate the presence of:

Cardiac Pacemaker _____ Absolute Contra-indication _____

Clip on a Cerebral Aneurysm _____ Absolute Contra-indication _____

Ocular or Cochlear Implants _____ Absolute Contra-indication _____

Ocular Foreign Body _____ Absolute Contra-indication _____

Cardiac Prosthetic Valve _____ Specify _____

Post Coronary Bypass Graft _____ Epicardial Pacer Wires _____

Neurostimulator _____ Spine _____

Metal Prosthesis _____ Specify _____

Penile Implants _____ Specify _____

IVC Filter _____

Brain Surgery _____ Specify _____

Other Surgery? _____ Specify _____

Is Patient Pregnant? _____

Body Piercing? _____

Has patient ever been injured by a metallic foreign body particularly to the eyes, at work or in other circumstances, which was not removed? (ex. Explosion, gun shot, accident at work, accident on the road, accident at war) Yes No

* For an MRI of the brain avoid make-up

I have reviewed the above questionnaire with my physician, it is corrected and I consent to the MRI Exam.

Physician Signature

Patient Signature

Date



MRI Requisition Form

Name: _____ Date of Birth: D _____ M _____ Y _____

Telephone: (_____) _____ Work Tel: (_____) _____

TYPE OF EXAM:

- | | | | |
|---|---------------------------------------|----------------------------|----------------------------------|
| <input type="checkbox"/> Brain/Cerveau | <input type="checkbox"/> Ankle | <input type="checkbox"/> L | <input type="checkbox"/> R |
| <input type="checkbox"/> Cervical Spine | <input type="checkbox"/> Elbow | <input type="checkbox"/> L | <input type="checkbox"/> R |
| <input type="checkbox"/> Sella Turcica | <input type="checkbox"/> Knee | <input type="checkbox"/> L | <input type="checkbox"/> R |
| <input type="checkbox"/> Dorsal Spine | <input type="checkbox"/> Shoulder | <input type="checkbox"/> L | <input type="checkbox"/> R |
| <input type="checkbox"/> I.A.C. | <input type="checkbox"/> Wrist | <input type="checkbox"/> L | <input type="checkbox"/> R |
| <input type="checkbox"/> Lumbar Spine | <input type="checkbox"/> M.R.C.P. | <input type="checkbox"/> L | <input type="checkbox"/> R |
| <input type="checkbox"/> M.R.A. Region | <input type="checkbox"/> Abdomen | <input type="checkbox"/> L | <input type="checkbox"/> R |
| <input type="checkbox"/> Pelvis | <input type="checkbox"/> Other Region | <input type="checkbox"/> L | <input type="checkbox"/> R _____ |

CLINICAL INFORMATION (IMPORTANT):

CSST: File Number: _____ SAAQ: File Number: _____

PHYSICIAN

Name: _____

Address: _____

Telephone: (_____) _____ Fax: (_____) _____

License: _____ Report in English

Physician Signature

Date