MRI Requisition

Suite 108, 3001 Gordon Avenue
Coquitlam, British Columbia V3C 2K7
tel 604.941.8780 fax 604.941.8709
www.medrayimaging.com

We will contact your patient and book the appointment within 2-3 days of receiving the requistion.

Interpreter needed?: ☐ Yes ☐ No

Language:

Patient Last name: First name:

Address: Birth date:

City: Patient phone (day):

Postal code: Gender: ☐ M ☐ F Patient phone (night):

Medical Plan # WCB/ ICB Claim #

☐ WCB ☐ RCMP ☐ Self Pay ☐ Other:

Patient Screening

Appointment will not be scheduled until the following questions are answered.

1. **Has the patient ever had a metallic foreign body in the eye or ever been a grinder, metal worker or welder?** If so, orbital x-rays are required. ☐ No ☐ Yes

2. **Does the Patient have:**
   a. Cardiac pacemaker, wires or defibrillator? ☐ No ☐ Yes
   b. Cerebral aneurysm clip? ☐ No ☐ Yes
   c. Implanted stents or filters? ☐ No ☐ Yes
   d. Electrical stimulator device? ☐ No ☐ Yes
   e. Shrapnel/ bullets? ☐ No ☐ Yes
   f. Middle ear prosthesis or Cochlear implant? ☐ No ☐ Yes
   g. Other metallic devices or objects in or on body (e.g. surgical clips, staples, heart valves, orthopedic hardware, other)? ☐ No ☐ Yes
   Details:

3. **Is the patient pregnant or nursing?** LNMP ☐ No ☐ Yes

4. **Is the patient claustrophobic?** ☐ No ☐ Yes

5. **Is sedation required?** (If sedation is required, the patient will be unable to drive following the exam.) ☐ No ☐ Yes

6. **How much does the patient weigh?** (Max weight allowed 350 lbs)

Medical History

Exam requested:

Present complaint/ relevant history:

Relevant prior examinations (CT/ US/ MRI/ X-RAY) (list and attach reports):

Renal function (Creatinine or eGFR):

Allergies/asthma (specify):

Known or communicable infectious diseses (specify):

Physician Information

Referring Physician: Physician signature:

Address: Phone:

City: Fax:

Copies to: