



MRI REQUISITION

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www.medrayimaging.com

We will contact your patient directly to book the appt. Please ensure phone number is present.

Interpreter required? Yes No

Language: _____

Patient Last name: _____ First name: _____

Address: _____ Birth date: _____

City: _____ Patient phone: _____

Postal code: _____ Gender: M F

Medical Plan # _____ WCB/ ICBC Claim # _____

WCB RCMP Self Pay

Medical History

Exam requested: _____

Present complaint/ relevant history: _____

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?** No Yes
If so, orbital x-rays are required.

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?** No Yes
LMP _____

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

5. **Is sedation required?** No Yes
(Please ensure the patient has a prescription, will not be provided onsite)

6. **How much does the patient weigh?**
(Limit is 340 lbs.)

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

Renal function (Creatinine or eGFR): _____

Allergies/asthma (specify): _____

Known or communicable infectious diseases (specify): _____

Physician Information

Referring Physician: _____ Physician signature: _____

Address: _____ Phone: _____

City: _____ Fax: _____

Copies to: _____