



KELOWNA
MRI Request Form
Fax: 250.860.4546

#101 3320 Richter Street
 Kelowna BC V1W 4V5
 Phone: 250.860.4848
 Toll Free Phone: 1.866.966.4848

PATIENT DETAILS

Last Name: _____ First Name: _____
 Address: _____ Postal Code: _____
 Date of Birth: (dd/mm/yy) _____ Male Female Weight: _____
 Daytime Phone: _____ Cell: _____ Home Phone: _____
 WCB Claim No: _____ Third Party Payor: _____

PATIENTS WILL NOT RECEIVE AN MRI IF THEY HAVE ANY OF THESE:

Cardiac Pacemaker • External Pacer Wires • Cochlear Implants • Aneurysm Clips • Neurostimulator • Programmable Hydrocephalus Shunts • Patients under 16 years who require sedation or contrast agent

Does the patient have any of the above?
 If yes , please circle. Yes No

Does the patient have a cardiac valve, stent
 or any other implanted surgical device? Yes No
 Please provide details in writing.

Has the patient ever had a metallic
 foreign body in their eye? Yes No

Orbit X-Ray Ordered? Yes No
 If yes,where? _____

PATIENT INFO

Pregnant: Yes Renal Function Normal: No GFR: _____
 Breast Feeding: Yes Claustrophobic: Yes

MRI EXAM REQUESTED:

HEAD & NECK	<input type="checkbox"/> Brain	<input type="checkbox"/> Auditory Canal (IAC)
	<input type="checkbox"/> Pituitary	<input type="checkbox"/> Soft Tissue Neck
	<input type="checkbox"/> Orbits	<input type="checkbox"/> TM Joints
BODY	<input type="checkbox"/> Chest	<input type="checkbox"/> Abdomen & Pelvis
	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Core Body
	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Other
SPINE	<input type="checkbox"/> Cervical	<input type="checkbox"/> Sacrum and SI Joints
	<input type="checkbox"/> Thoracic	<input type="checkbox"/> Total Spine
	<input type="checkbox"/> Lumbar	<input type="checkbox"/> Brachial Plexus
BREASTS	<input type="checkbox"/> Implants <input type="checkbox"/> Yes	TYPE: _____
MUSCULO-SKELETAL	Knee <input type="checkbox"/> RT <input type="checkbox"/> LT	Ankle <input type="checkbox"/> RT <input type="checkbox"/> LT
	Shoulder <input type="checkbox"/> RT <input type="checkbox"/> LT	Wrist <input type="checkbox"/> RT <input type="checkbox"/> LT
	Hip <input type="checkbox"/> RT <input type="checkbox"/> LT	Elbow <input type="checkbox"/> RT <input type="checkbox"/> LT
VASCULAR	<input type="checkbox"/> Renal Arteries	<input type="checkbox"/> Other
	<input type="checkbox"/> Circle of Willis	
	<input type="checkbox"/> Carotids	

CLINICAL HISTORY:

If there is relevant prior imaging, please provide reports with requisition:
 (eg, MR, CT, US, Mammogram, Nuc Med, X-Ray, Angiogram ,Other)

PHYSICIAN DETAILS

Name: _____ Date: _____
 Address: _____ Signature: _____
 Phone: _____ Physician's College Number: _____
 Fax: _____