

MRI REQUISITION Nanaimo MRI

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Location: 1097 Nelson Street, Nanaimo, BC V9S 2K1

Ordering Physician _____ MSP #: _____
PRINT Full Name

Signature: _____

Phone #: _____ Fax #: _____

Extra Copies to:

Exam(s) Requested

Reason for Exam(s)
(Do not attach consults or letters. Must give concise history.)

Previous
Location: _____ CT or MRI

Complete for ALL Patients

Height: _____ (cm or ft) Weight: _____ (Kg or lbs)

Allergies : _____

Is the patient pregnant? Yes No

Infection Control Precautions? Yes No

If Yes, specify type: _____

Is there a clinical suspicion of renal dysfunction ? Yes No

If Yes,
eGFR: Value: _____ Date of result: _____

PHN: _____

Patient Name: _____

Address: _____

Daytime Phone : _____

Home Phone: _____

Sex: M F DOB (dd/mm/yyyy): _____

Does the patient have ANY implanted devices?

Cardiac Pacemaker/Defibrillator, Artificial Heart Valve,
Cerebral Aneurysm Clip, Neurostimulator, Cochlear Implant,
Penile Implant or Cranial Shunt.

Yes No

IF YES: Please attach operative report or a copy of the patient's
implant identification card for patient safety. We cannot
book until the implant is verified as MRI compatible.

PLEASE NOTE: Cardiac Stents or any
Orthopedic Implants are excluded.

Any possibility of a metal orbital foreign body? Yes No
If yes, an AP Orbital X-ray is required.

Ordered Result: _____

Is the patient Claustrophobic? Yes No
If Yes, physician to arrange for oral sedation.

Does the patient need assistance with mobility? Yes No
If Yes, what is required? _____

Has the patient had surgery in the area of exam? Yes No

Surgery Date: _____

FOR DEPARTMENT USE ONLY

With
 Without

Appointment Date: _____

Time: _____