Fraser Valley MRI

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MRI REQUEST AND SCREENING FORM

- **For patient safety, MRI examinations will not be booked until all 3 parts of this form have been completed**
- **All relevant information and imaging examinations must be forwarded for review by the MRI physician prior to the examination**

PART 1 PATIENT AND PHYSICIAN INFORMATION

PATIENT NAME Last First Middle	REFERRING PHYSICIAN
ADDRESS	ADDRESS
PHONE Home: Other:	PHONE FAX
DATE OF BIRTH (yyyy/mm/dd) SEX [ ]M [ ]F	ADDITIONAL COPIES TO:
[ ]WCB [ ]RCMP [ ]PATIENT [ ]OTHER(specify) MEDICAL PLAN NUMBER	

PART 2 MEDICAL HISTORY QUESTIONNAIRE

REGION TO BE EXAMINED

NEURO
[ ]Brain [ ]Orbits [ ]Sella [ ]IAC
[ ]C-spine* [ ]T-spine* [ ]L-spine* [ ]Sacrum
[ ]SI joints [ ]Neck (soft tissue) [ ]Brachial Plexus
***Please specify spinal levels**

MSK
[ ]TM joints (bilateral) [ ]Shoulder** [ ]Elbow**
[ ]Wrist** [ ]Hip** [ ]Knee** [ ]Ankle**
[ ]Hand or Finger** [ ]Foot or Toes**
****Specify side (L,R,both)**
please note that both sides means 2 separate exams

BODY
[ ]Adrenals [ ]Liver [ ]MRCP [ ]Pancreas
[ ]Kidneys [ ]Pelvis

VASCULAR
[ ]Circle of Willis [ ]Carotids
[ ]MRV [ ]Renal MRA

CLINICAL HISTORY

RELEVANT PRIOR EXAMINATIONS
(e.g., MRI, CT, US, Nuc Med, X-Ray, Angiogram, Other)
Please list and/or attach relevant reports

PART 3 PATIENT SCREENING INFORMATION

FOR PATIENT SAFETY, THE PATIENT CANNOT BE SCHEDULED UNTIL THE FOLLOWING QUESTIONS HAVE BEEN ANSWERED*

Yes	No	
[ ]	[ ]	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**.
		2. Does the patient have:
[ ]	[ ]	• cardiac pacemaker, wires or defibrillator (**ABSOLUTE CONTRAINDICATION**)?
[ ]	[ ]	• cerebral aneurysm clip(**ABSOLUTE CONTRAINDICATION**)?
[ ]	[ ]	• ocular (eye) or cochlear (ear) implant (**ABSOLUTE CONTRAINDICATION**)?
[ ]	[ ]	• artificial cardiac valve? Make and model _____
[ ]	[ ]	• electrical stimulator for nerves and bones?
[ ]	[ ]	• shrapnel/bullets?
[ ]	[ ]	• metallic devices or objects in or on body (e.g., surgical clips, staples, metallic vascular stents, orthopedic hardware, other)? Explain _____
[ ]	[ ]	3. Is the patient pregnant or nursing?
[ ]	[ ]	4. Has the patient had surgery in the area of interest? Explain _____
[ ]	[ ]	5. Is the patient claustrophobic? If sedation (Ativan; to be supplied by referring physician), is required, the patient will be unable to drive following exam.
		6. How much does the patient weigh? _____ (max wt allowed 350 lbs)

Physician signature