Welcome Back
MRI and Pain Management Centre

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MRI Exam Requisition Form

Surname:	First Name:	Date of Birth:	Phone:
Address:	City:	Province:	Postal Code:
WCB Claim Number:		PHN:	Third Party Payer:

MRI Exam

Brain (Standard - neurological screening)
Brain (IAC)
Brain (MS)
Brain (Positional H/A; Chiari) (2 positions)
Brain (Trauma)
Brain (Seizure)
Brain (MRI plus MRA)
Brain (Tumor)
Pituitary (incl. routine Brain)

Full CNS MS Exam (Brain & full cord)

Bilateral TM Joints
Brachial Plexus

Soft Tissue Neck
Cervical Spine (Flexion/Extension)

Thoracic Spine (Standard-Single Position)

Lumbar Spine (Standard-single Position)
Lumbar Spine (Flexion/Extension)
Lumbar Spine - Post-Op
Lumbar Spine plus SI Joints (Multi-position)

SI Joints (With Gadolinium)
Scoliosis
Complete Spine (Single Position Cervical, Thoracic, Lumbar)
Complete Spine (Multi Positional Cervical, Thoracic, Lumbar)

Single Hip Right
Single Hip Left

Pelvis
Pelvic Floor

Shoulder ☐ R ☐ L
Elbow ☐ R ☐ L
Wrist / Hand ☐ R ☐ L
Single Hip ☐ R ☐ L

Bilateral Hips (wt bearing & non-wt bearing)
Knee ☐ R ☐ L
Ankle/Foot ☐ R ☐ L

Shoulder Arthrogram ☐ R ☐ L
Ankle Arthrogram ☐ R ☐ L

MR Angiography (MRA)
MRA Brain (aneurysm screening)
MRA Carotids

Relevant History:

Relevant Prior Exam(s):

☐ **MRI**
☐ **CT**
☐ **X-Ray**
☐ **Nuclear Med**
☐ **Mammogram**

Date(s):
Locations(s):

Creatinine & eGFR required within 30 days if client:

is 70 yrs or older
is diabetic
has renal dysfunction
has hypertension
has severe hepatic disease

Creatinine:_____ mcmol/L
eGFR:_____ ml/min
Date:_____

Requesting Physician:		Copy Report To:		
Address:	City:	Province:	Postal Code:	MSP: