



www. MRIappointments.com
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MRI REQUISITION FORM

Patient Name:(last) _____ (first) _____
 Address: _____

 City: _____ Postal Code: _____
 Home Telephone: (____) _____
 Business Telephone: (____) _____
 Date of Birth (mm/dd/yy) _____
 Height: _____
 Weight: _____
 Male Female

Note:
 The MRI Test will be conducted at Thumb MRI Centre in Cass City Michigan. 75 min. from Sarnia
 Patients must bring a certified cheque to the MRI facility on the day of their test.

AREA TO BE SCANNED: _____

 CLINICAL INFORMATION; _____

 SPECIFIC REASON FOR TEST: _____

OTHER TESTS and RESULTS to DATE
 Please forward any relevant reports, X-Ray Films, CT Scans or Ultrasounds
 MRI _____
 X-Ray _____
 CT _____
 US _____
 Myelogram _____
 Angiogram _____
 Nuc. Med. _____
 Arthroscopy _____
(date and location of test)

DOES the PATIENT have any of the following:	YES	NO		YES	NO
Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Has patient ever worked as a metal worker?	<input type="checkbox"/>	<input type="checkbox"/>
Artificial cardiac valve	<input type="checkbox"/>	<input type="checkbox"/>	Has patient ever had metal fragments in or around the eyes or have been exposed to metal dust or slivers in the workplace?	<input type="checkbox"/>	<input type="checkbox"/>
Model# _____ Type _____ Year _____			FB eye: <input type="checkbox"/> RT <input type="checkbox"/> LT	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysm Clip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Metallic <input type="checkbox"/> Non-Metallic	<input type="checkbox"/>	<input type="checkbox"/>
Neurostimulator	<input type="checkbox"/>	<input type="checkbox"/>	Dental appliances ...dentures, retainer, braces	<input type="checkbox"/>	<input type="checkbox"/>
Embedded shrapnel or bullets	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic device...limb, eye, joint, ear	<input type="checkbox"/>	<input type="checkbox"/>
Porta Cath	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a chance the patient is pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, please describe: _____		
Body piercing and tattoos	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Is the patient subject to claustrophobia? (If YES, patient's physician to prescribe medication.)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Cochlear or other implanted device(s) or metallic objects in body?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Does the patient have a history of impaired renal function?	<input type="checkbox"/>	<input type="checkbox"/>	} If yes to these three questions and the patient requires gadolinium contrast (MRI contrast), a recent creatinine score must accompany the requisition.		
Is the patient currently on dialysis?	<input type="checkbox"/>	<input type="checkbox"/>			
Is the patient over 70 years of age?	<input type="checkbox"/>	<input type="checkbox"/>			

Referring Physician: _____ Copies to be Sent to: _____
 Specialty: _____ Regist ID# _____ Address: _____
 Tel: (____) _____ Fax: (____) _____
 Address: _____

 Physician's Signature: _____ Tel: (____) _____ Fax: (____) _____