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? Please provide details in writing. ❑ **Yes** ❑ **No**

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

Does the patient have a known or suspected communicable disease: ❑ Yes

MRI EXAM REQUESTED:

CLINICAL HISTORY:

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

HEAD & NECK	❑ Brain	❑ Auditory Canal (IAC)
	❑ Pituitary	❑ Soft Tissue Neck
	❑ Orbits	❑ TM Joints
BODY	❑ Chest	❑ Abdomen & Pelvis
	❑ Abdomen	❑ Core Body
	❑ Pelvis	❑ Other
SPINE	❑ Cervical	❑ Sacrum and SI Joints
	❑ Thoracic	❑ Total Spine
	❑ Lumbar	❑ Brachial Plexus
[redacted]		
MUSCULO-SKELETAL	Knee ❑ RT ❑ LT	Ankle ❑ RT ❑ LT
	Shoulder ❑ RT ❑ LT	Wrist ❑ RT ❑ LT
	Hip ❑ RT ❑ LT	Elbow ❑ RT ❑ LT
VASCULAR	❑ Renal Arteries	❑ Other
	❑ Circle of Willis	
	❑ Carotids	

PHYSICIAN DETAILS

Date: _____

Name: _____ Signature: _____

Address: _____ Physician's College Number: _____

Phone: _____ Fax: _____