Nanaimo MRI

MRI REQUISITION

Tel. 250-591-53 11 Fax. 250-591-5312
info@nanaimomri.ca www.nanaimomri.ca
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: _____