MRIAppointments.com

MRI Requisition
Diffusion Tensor Imaging and Functional MRI Testing

(For use with Disability Insurance or Medical-Legal Situations only)

Patient Last Name:_____First:_____

Pronoun: ☐ He/Him ☐ She/Her ☐ They/Them

Address:_____

City:_____ Prov: _____ Postal Code:_____

Date of Birth (mmm/dd/yy):_____Phone (H): _____ (C):_____

E-Mail: _____ Height_____ Weight:_____ ☐ Kg ☐ Lbs

WSIB / Insurance Claim #: _____ Date of Loss: _____

Exam:	Relevant Tests to Date
☐ Head/Brain	Please forward any relevant reports,
	☐ MRI _____
	☐ CT _____
CLINICAL INFORMATION/ RELEVANT HISTORY(required)	☐ SPECT _____
	☐ Xray _____
	☐ Other : _____
	(date and location of test if known)

MRI Safety Questions					
	Yes	No		Yes	No
Has patient had a previous MRI?	☐	☐	Heart Pacemaker/ Defibrillator	☐	☐
Metallic foreign body in the eye.	☐	☐	Brain Aneurysm clip.	☐	☐
If yes, was it removed?	☐	☐	Spine neurostimulator	☐	☐
Pregnant or breastfeeding?	☐	☐	Body jewelry, piercings, tattoos?	☐	☐
Claustrophobic?	☐	☐	Ear implants (excluding hearing aids)	☐	☐
Drug allergies	☐	☐	Implanted devise or surgeries	☐	☐
Mobility aids required (example: wheel chair, stretcher etc.)?	☐	☐	If yes, please provide details (procedure type, make/model, date)		
Transdermal patches	☐	☐			

Referring Physician (First Last):_____ CPSO: _____

Address: _____ City: _____ Prov: _____ Post: _____

Tel: _____ Fax: _____ Signature: _____

Copies to:

Physician (First Last): _____ Ph:_____ Fax: _____

Radiologist Use Only: Comments/Protocol