Alberta Health Services

MRI Request

Patient label here or information below is required	
Last Name	First Name
Birthdate *(yyyy-Mon-dd)*	Gender
Address (street, city, province, postal code)	
PHN	Daytime Phone
Inpatient location	WCB Claim Number

- Fax to Diagnostic Imaging; fax numbers listed at http://www.albertahealthservices.ca/diagnosticimaging
- *Urgent/Emergent requests must be discussed by direct consultation with the radiologist*

Preferred Facility

Referring Physician (***PRINT*** *first and last name*)	Physician Phone *(required)*	Physician Fax *(required)*	Contact Number for Critical Test Results *(required)*

Signature	Date *(yyyy-Mon-dd)*	Copy to Physician *(first and last)*	Copy to Fax

Specific anatomical area to be examined

Relevant clinical history/presumptive diagnosis

Clinical question to be answered

Relevant Previous Imaging Studies

Location	Type	Date *(yyyy-Mon-dd)*	Attached copy
			☐ No ☐ Yes

Safety Screening: MRI Exams will **not** be booked unless the following sections are completed. **Please review with the patient.**

Screening Item	**No**	**Yes**	**If Yes:**
Cardiac pacemaker, defibrillator	☐	☐	Make/Model: Year:
Coronary artery stents	☐	☐	Make/Model: Year:
Metallic vascular clips *(aneurysm clips)*	☐	☐	Make/Model: Year:
Implanted Power Compatible CVC	☐	☐	Make/Model: Year:
Metallic foreign body/implants	☐	☐	Specify:
Has the patient ever had a metal foreign body in the eye	☐	☐	n/a
Any previous surgery	☐	☐	Date: Area: Date: Area:
Hypertension or long standing insulin dependent diabetes	☐	☐	Specify:
Claustrophobic	☐	☐	Sedation type ☐ Oral ☐ I.V.
Isolation precautions	☐	☐	Specify:
Pregnant	☐	☐	n/a
Mechanical lift/transfer required	☐	☐	Specify:

Weight ☐ kg ☐ lbs	Previous Treatment ☐ Chemotherapy ☐ Radiation Therapy ☐ Steroids	Pediatric General Anesthesia
Height ☐ cm ☐ in	If yes, Where: When:	Is GA required? ☐ No ☐ Yes

Renal Insufficiency ☐ No ☐ Yes On Dialysis ☐ No ☐ Yes ▶ run days: ________	If no current results available, please indicate date ordered *(yyyy-Mon-dd)*
Serum Creatinine *(within 90 days)*	GFR / Date *(yyyy-Mon-dd)*

Department Use Only	Priority ☐ OP1 ☐ OP2 ☐ OP3 ☐ OP4, *specify date:*		
Radiologist	Protocol		Enhanced ☐ No ☐ Yes
Date Received *(yyyy-Mon-dd)*	Time Received *(hh:mm)*	Appointment Date *(yyyy-Mon-dd)*	Appointment time *(hh:mm)*