Alberta Health Services

MRI Request

- ALL fields must be completed in order to process request
- Fax to Diagnostic Imaging; fax numbers listed at *http://www.albertahealthservices.ca/diagnosticimaging*
- *Urgent/Emergent requests must be discussed by direct consultation with a radiologist*

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
PHN	ULI ☐ Same as PHN / MRN
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X) ☐ Unknown	

Preferred Facility		Inpatient Location	
Patient Phone Number *(Cell # preferred)*		Patient Address	
City	Postal Code	WCB Claim Number	
Ordering Provider Name	Provider ID	Department ID	
Provider Fax	Provider Phone	Contact Number for Critical Test Results	
Provider Address/Location	City	Postal Code	
Locum ☐ No ☐ Yes ► Primary Provider Name and Provider ID _____			
Signature	Date *(dd-Mon-yyyy)*	Copy to Provider *(last,first and middle)*	Copy to Fax
Requested Procedure			
Reason for Exam			
Clinical question to be answered			

Relevant Previous Imaging Studies

Modality	Location	Date *(dd-Mon-yyyy)*	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:**
Pregnant ☐ n/a	☐	☐	Date of LMP:
Pediatric / Special Needs	☐	☐	Requires sedation ☐ No ☐ Yes ☐ Anesthesia
Claustrophobic	☐	☐	Sedation type ☐ Oral ☐ I.V.
Cardiac pacemaker, defibrillator	☐	☐	
Cochlear Implant	☐	☐	
Deep Brain Stimulator	☐	☐	
Metallic vascular clips *(aneurysm clips)*	☐	☐	
Implanted Power Compatible CVC	☐	☐	
Metallic foreign body/implants	☐	☐	Specify:
On Dialysis	☐	☐	
Hypertension or long standing insulin dependent diabetes	☐	☐	Specify:
Mechanical lift/transfer required	☐	☐	Specify:
Previous surgery	☐	☐	Date: _____ Area: _____ Date: _____ Area: _____

Previous Treatment ☐ Chemotherapy ☐ Radiation Therapy ☐ Steroids	Weight ☐ kg ☐ lbs
If yes, Where: _____ When: _____	Height ☐ cm ☐ in

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