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: (must be < 350lbs.) ______

Home Phone: ______ Cell: ______ Work/Other Phone: ______

WorkSafeBC Claim#: (if applicable) ______ Third Party Payor: (if applicable) ______

PHN#: ______

PATIENTS WILL NOT RECEIVE AN MRI IF THEY HAVE / ARE ANY OF THE FOLLOWING:

Cardiac Pacemaker • Cochlear Implants (non-MRI Conditional) • Intracranial Aneurysm Clips • Neurostimulator • Programmable VP Shunt • Over 350lbs • Pregnant • Under 16 years who require sedation (pediatric requests are dealt with on a case-by-case basis)

Does the patient have a cardiac valve, stent or any other implanted surgical device? ❑ Yes ❑ No

For stents, please attach O.R. report, or note facility in which stent was implanted.

Is there a reasonable chance the patient has any metallic slivers in the eye(s) (e.g. metal workers)? ❑ Yes ❑ No

If yes or patient unsure, order x-ray.

PATIENT INFO Breast Feeding: ❑ **Yes** Claustrophobic: ❑ **Yes**

Please note that Image One MRI is unable to provide sedation to your patient. Please prescribe accordingly ahead of time.

Does the patient have a known communicable disease? (eg: MRSA, VRE, TB) ❑ **Yes** ❑ **No** If Yes, please elaborate:

BODY PART(S) REQUESTED:

CLINICAL HISTORY: (must accompany each request)

If a contrast agent is required, patients with known kidney issues and those over 60 will require a recent GFR (within 90 days). If unsure please call our office.

Previous relevant imaging: MRI ❑ CT ❑ X-ray ❑ U/S ❑ Nuclear Medicine ❑ Mammogram ❑ Angiogram ❑ Other ❑

If there is relevant prior imaging, please submit reports with the requisition

PHYSICIAN DETAILS Date: ______

Name: ______ Signature: ______

Address: ______ Physician's College Number: ______

Phone: ______ Fax: ______ CC Report to: ______