2158 - 13353 Commerce Parkway
Richmond, BC V6V 3A1
Tel: 778-239-7674
Fax: 778-239-7675
Email: req@prioritymri.ca

MRI REQUISITION

Please complete all 3 sections and submit by email or fax

PART 1 PATIENT AND PHYSICIAN INFORMATION

PATIENT NAME: Last First Middle	**REFERRING PHYSICIAN NAME:** Billing #
ADDRESS:	**ADDRESS:**
PHONE: Home Other	**PHONE:**
EMAIL:	**FAX:**
DATE OF BIRTH: yyyy/mm/dd **SEX:** [ ]M [ ]F	**Additional Copies to:**
PHN: **WEIGHT:**	

PART 2 MEDICAL

MRI EXAM REQUESTED:

Please provide details such as: Spinal Levels, L/R side etc.

CLINICAL HISTORY:

PART 3 PATIENT SCREENING

Cardiac Pacemaker or Defibrillator	Yes / No
Cerebral Aneurysm Clip	Yes / No
Internal Electrodes or Wires	Yes / No
Eye or Ear Implant	Yes / No
Metallic Orbital Foreign Body	Yes / No
Shrapnel or Bullet	Yes / No
Intravascular Coil, Stent or Filter	Yes / No
Breast Tissue Expander	Yes / No
Infusion Pump or Stimulator	Yes / No
Other:	Yes / No
Is the Patient Pregnant?	Yes / No
Is the Patient Breastfeeding?	Yes / No
Is the Patient Claustrophobic?	Yes / No

RELEVANT PRIOR EXAMS: (e.g. MRI, CT, Nuc Med, X-Ray, Angiogram, Other)

PHYSICIAN SIGNATURE: