

MRI REQUISITION FORM

Summerside Diagnostic Imaging Centre



107 Walker Ave, Summerside, PE C1N4K2

Phone: (902) 436-1119

Fax: (902) 436-0762

Email: info@summersideimaging.com

PATIENT INFORMATION	
Name:	Address:
Telephone:	Height and weight:
Date of Birth (YYYY/MM/DD):	HCN:

REFERRING PRACTITIONER	
Name:	Telephone:
Address:	Fax:

EXAM INFORMATION – Completed by referring practitioner	
Requested scan(s):	Relevant history/clinical indication:

Practitioner signature:	Date:
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SCREENING QUESTIONS – Completed by referring practitioner			
Any incident with metal in eyes or body	Yes	No	Lumbar Spine Surgery
If yes, please explain:			Yes No
If metal in eyes and no previous x-ray, orbital x-ray must be completed.			If yes, what type or surgery:
If metal in body, further investigation may be required.			
Pacemaker/ICD:	Yes	No	Aneurysm Clips or Coils (or other brain implant):
			Yes No
Eye or Ear implant:	Yes	No	Insulin Pump/sensor:
			Yes No
Any chance of pregnancy:	Yes	No	Other Implants:
		N/A	

CONTRAST SCREENING QUESTIONS (If exam requires contrast)			
Diabetic	Yes	No	Hypertension
			Yes No
Renal Disease or injury	Yes	No	Kidney Transplant or single kidney
			Yes No
Dialysis	Yes	No	Known low GFR or creatinine levels
			Yes No

Internal use:

MRI fee:	Accession #:
Appt date and time:	Protocol:

Contrast <input type="checkbox"/> Type and amount: Lot/exp: Injection @
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