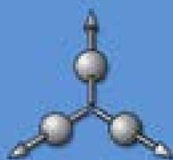

# Peace Regional MRI

115 - 10200 8th St., Dawson Creek, BC, V1G 3P8 Tel. 250-784-0040

PLEASE SIGN AND COMPLETE MRI REQUISITION.

**FAX TO:**
**1-888-898-9857**
OR
**E-MAIL TO:**
**orders@peacemri.com**

INCOMPLETE OR ILLEGIBLE REQUISITIONS WILL BE RETURNED.

**BODY PART TO BE EXAMINED:**

HEAD
IACS
TMJS
SELLA
ORBITS

CERVICAL SPINE
THORACIC SPINE
LUMBAR SPINE
SACRUM
S/I JOINTS
L/S PLEXUS

NECK
BRACHIAL PLEXUS

CARDIAC
LIVER
MRCP
PANCREAS
KIDNEYS
ENTEROGRAPHY
PELVIS

WHOLE BODY SCREEN
(SEE WEBSITE FOR DETAILS)

MRA HEAD
MRA CAROTIDS
MRA AORTA
MRA RENALS
MRA RUNOFF

| | Rt | Lt | Bilat | Arthrogram |
|---|---|---|---|---|
| SHOULDER | | | | |
| ELBOW | | | | |
| WRIST | | | | |
| HAND | | | | |
| HIP | | | | |
| KNEE | | | | |
| ANKLE | | | | |
| FOOT | | | | |

PATIENT NAME: ______________________________

ADDRESS: ______________________________

CITY: ______________________________

PROVINCE: ____________ POSTAL CODE: ____________

TELEPHONE (HOME): ______________________________

TELEPHONE (MOBILE): ______________________________

TELEPHONE (WORK): ______________________________

DATE OF BIRTH: ____________ ( MM / DD / YYYY ) HEIGHT: ____________

MALE: FEMALE: WEIGHT: ____________

MSP: WSBC: ICBC: RCMP: MSP/CLAIM #: ____________

HAS THE PATIENT HAD METAL FRAGMENTS IN THE EYE THAT HAVE NOT BEEN COMPLETELY REMOVED: NO YES
**IF "YES" PLEASE ORDER SCREENING X-RAY OF THE ORBITS AND FORWARD THE RESULTS.**

DOES THE PATIENT HAVE ANY IMPLANTED MEDICAL DEVICES (PACEMAKERS/ICDS, CEREBRAL ANEURYSM CLIPS, COCHLEAR IMPLANTS, NEUROSTIMULATORS, INFUSION PUMPS, ETC.): NO YES

SPECIFY TYPE: ______________________________

IS THE PATIENT CLAUSTROPHOBIC, REQURING SEDATION: NO YES
**IF "YES", PLEASE PRESCRIBE THE PATIENT AN ORAL SEDATIVE.**

IS THE PATIENT PREGNANT (DUE DATE, IF YES): ____________ NO YES

IF THE PATIENT REQUIRES MRI CONTRAST PLEASE ATTACH RECENT (<3 MONTHS) eGFR RESULTS: eGFR ________ DATE ________

HISTORY / INDICATION / TENTATIVE DIAGNOSIS:
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________

REFERRING PHYSICIAN'S SIGNATURE ____________ PRINT NAME ____________ FAX REPORT TO #: ____________

ADDITIONAL COPIES TO: ______________________________

**PLEASE FORWARD ANY RELEVANT PREVIOUS IMAGING REPORTS PRIOR TO THE APPOINTMENT DATE.**

APPOINTMENT DATE: ____________ TIME: ____________
*MRI DEPARTMENT USE ONLY*

**This form is available on-line at: http://www.peacemri.com**

Revised Nov. 13, 2016