IRM MONCTON MRI

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Patient Information

Name: _____

Address: _____

Unique ID: _____ Medicare #: _____

Date of Birth: _____

Phone #(s): _____

Referring Physician: _____

Telephone: _____ Fax: _____

Collaborating Physician: _____

Telephone: _____ Fax: _____

Copies of report to: _____

- ☐ **MRI Requisition**
- ☐ **Ultrasound Requisition**
- ☐ **C-Arm - Injection Service**

1. AREA TO BE SCANNED:

2. CLINICAL QUESTION TO BE ANSWERED:

3. CLINICAL HISTORY / PERTINENT INFORMATION:

Essential Patient Data / Risk Factors

Diabetic	☐ Yes ☐ No	Multiple Myeloma	☐ Yes ☐ No
Renal failure	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No
Cardiovascular Disease	☐ Yes ☐ No	Hepatic Disease	☐ Yes ☐ No

Allergies ☐ Yes ☐ No *If Yes, (Please List)* _____

Creatinine_____ eGFR _____ Date: _____

Previous Surgery ☐ Yes _____ ☐ No

Claustrophobic ☐ Yes *(Please provide appropriate medication if required)* ☐ No

Patient is: ☐ Ambulatory ☐ Wheelchair Dependant

☐ WorkSafe NB ☐ DND ☐ RCMP ☐ Patient ☐ Other _____

Date: _____ Physician Signature: _____

For Departmental Use Only

Protocol:

Contrast: ☐ Yes ☐ No

Administered by: _____

Date Received: Scheduled Date/Time