CAMIS
Imaging Excellence

Central Alberta Medical Imaging Services
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MRI REQUEST FORM

PATIENTS WILL BE BOOKED AND CONTACTED WITH APPOINTMENT BY MRI BOOKING CLERK

Anatomical Region To Be Examined ______________________________

Clinical Information and Diagnosis ______________________________

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For patient SAFETY the MRI Examination will NOT be booked unless this section is complete.

YES	NO	
☐	☐	Is the patient pregnant?
☐	☐	Is the patient claustrophobic?
☐	☐	Has the patient had cardiac or neurosurgery?
☐	☐	Cardiac pacemaker?
☐	☐	Aneurysm clip or surgery?
☐	☐	Neurostimulator?
☐	☐	Middle ear prosthesis?

YES	NO	
☐	☐	Has the patient **EVER** injured their eye with metal?
☐	☐	Did the patient seek medical attention for that injury?
☐	☐	Does the patient have renal disease?
☐	☐	Does the patient have compromised renal function?
☐	☐	Is the patient on dialysis?

Patient Weight: ______________________________

Type, date and location of last surgical procedure: ______________________________

SEND ALL RELEVANT FILMS / REPORTS

Type of Exam	Location of Films	Exam Date
____________	____________	____________
____________	____________	____________

Physician's Name ______________________ Physician Signature ______________________

Physician Fax ______________________ CC ______________CC Fax ____________

TO BE COMPLETED BY CAMIS MRI DEPARTMENT

Date Received ______________________

App't Date ______________________

Time______________________ Patient Notified ☐

BILLING INFORMATION

Invoice To ______________________

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WCB Claim # ______________________

Date of Injury ______________________

____
Home Phone Work Phone

____
Last Name First Name

____
Birthdate Sex AHC#

Address ______________________

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CAMIS MRI CONSULT