

**CENTRAL BOOKING**

780-669-2222

Toll Free: 1-866-771-9446

Fax: 780-930-1593

\*no appointment needed  
for general x-ray**Meadowlark MRI**
 200 Meadowlark Health Centre  
 156 Street - 89 Ave  
 Edmonton, AB T5R 5W9  
 Phone: 780-444-5652  
 Fax: 780-444-5642
**FREE PARKING****PLEASE FILL OUT COMPLETELY** - an incomplete requisition may delay scheduling

NAME: \_\_\_\_\_ APPT. DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

MALE  FEMALE  Date of LMP: \_\_\_\_\_ DD/MM/YY WEIGHT: \_\_\_\_\_ PHN: \_\_\_\_\_

THIRD PARTY PAYMENT: \_\_\_\_\_ WCB CLAIM NUMBER: \_\_\_\_\_ DATE OF ACCIDENT: \_\_\_\_\_ DD/MM/YY

*\*Private facility payment is due on completion of MRI Scan, except for Third Party Patients\**

Please keep your appointment. If you don't cancel 24 hours prior to exam, you may be charged a \$25.00 fee.  
Remember that others with healthcare needs could use your appointment time.

**MRI EXAMINATION(S) REQUESTED**

<b>Neuro:</b>	<b>Body:</b>	<b>Extremity:</b>
<input type="checkbox"/> Brain	<input type="checkbox"/> Breast	<input type="checkbox"/> Knee
<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Chest Wall	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/> Abdomen (to crest)	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> Pelvis	
<input type="checkbox"/> Circle of Willis MRA	<input type="checkbox"/> Other (please specify) _____	

**PHYSICAL FINDINGS, PROVISIONAL DIAGNOSIS & RELEVANT HISTORY**PREVIOUS RELEVANT X-RAYS, ULTRASOUND, CT, MRI  No  Yes Where? \_\_\_\_\_ When? \_\_\_\_\_

REFERRING PHYSICIAN'S NAME: \_\_\_\_\_ REFERRING PHYSICIAN'S SIGNATURE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

COPY TO: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

*MRI uses a strong magnetic field. Some metallic items may interfere with the imaging or be potentially hazardous.  
Please complete the following checklist:*

YES NO

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Work with metal, including grinding or welding                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye injury with metal   |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear and/or eye implant/prosthesis                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Any type of heart surgery   |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker and/or pacer leads  |
| <input type="checkbox"/> | <input type="checkbox"/> | Any type of brain or skull surgery                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Any type of surgery in the past six weeks                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Any type of stent, electrical or mechanical device/implant/prosthesis |
| <input type="checkbox"/> | <input type="checkbox"/> | Any metal in body   |
| <input type="checkbox"/> | <input type="checkbox"/> | Any previous Colonoscopy or Gastroscopy                               |

**Note: Patients with any of the following must have a serum creatinine WITHIN THE LAST 90 DAYS.**

- Over 70 years of age
- Diabetic
- Renal Disease

If any of the above questions are marked "YES", we may need a recent x-ray prior to the MRI for the patient's safety.  
(If x-rays are already completed, please send the report with this signed request.) If there are any implanted devices please provide the make, model and serial number.  
**\*Patients with Pacemakers or Aneurysm clips will not be scanned.\***

MRI Exam Preparation

Please bring this signed request with you. **If you are unable to keep your appointment, please phone 780-669-2222 to reschedule it.**  
There is no facility to look after small children.

- All patients will complete an *MRI Patient Safety* form that the MR technologist will review with the patient prior to scanning.
- Patients requiring an MRI contrast for enhanced studies will also complete an *MRI Contrast Consent* form.
- If the patient has welded or grinded metal, and has a previous eye injury with metal, **orbit x-rays** must be performed prior to the MRI examination.
- Patients will be asked to remove all jewelry, piercings, watches, belts, keys, coins, credit cards and any other type of removable devices that are considered magnetic.
- Patients may be required to change into a patient gown depending on the examination type.

*Please note that all relevant reports should be faxed to the clinic immediately and previous x-ray/US/CT/MRI films must accompany the patient or be forwarded to the clinic prior to the appointment. Any relevant films that are not received may cause a delay in the reporting.*

Patients requiring oral sedation must obtain the sedation from their referring physician. A family member or friend must accompany the patient to drive him/her home following the procedure.

Brain  
Spine  
Extremities



No patient preparation required.

Chest Wall  
Breast



No patient preparation required.

Abdomen  
(kidneys/liver/pancreas)  
Pelvis



Patient should not eat or drink  
4 hours prior to the examination.

Medications may be taken as usual.

