

**Central Booking**  
780-669-2222

**Toll Free**  
1-866-771-9446

**Fax**  
780-930-1593

**Toll Free Fax**  
1-855-930-1593

To cancel or rebook your appointment, please call Central Booking: Mon-Fri: 8AM-7PM, Sat: 9AM-4PM, Sun: Closed

Name: \_\_\_\_\_ **Appointment Details:**  
 Address: \_\_\_\_\_ Date: \_\_\_\_\_  
 Phone: \_\_\_\_\_ DOB (mm/dd/yyyy) \_\_\_\_\_ Weight: \_\_\_\_\_ Time: \_\_\_\_\_  
 PHN: \_\_\_\_\_ M  F  Date of LMP: \_\_\_\_\_ Location \*MEADOWLARK - MRI & CT\*  
156 Street - 89 Ave

**Third Party Payment Information**

Insurance: \_\_\_\_\_ Date Of Accident: \_\_\_\_\_ W.C.B.  Claim Number: \_\_\_\_\_  
*\*Private facility payment is due on completion of MRI/CT Scan, except for Third Party Patients\**

**1 MRI Examination(s) Requested**

<p><b>Neuro</b></p> <input type="checkbox"/> Brain <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Intracranial MRA	<p><b>Body</b></p> <input type="checkbox"/> Breast <input type="checkbox"/> Prostate <input type="checkbox"/> Pelvis <input type="checkbox"/> Abdomen (To Crest) <input type="checkbox"/> Enterography	<p><b>Extremity</b></p> <input type="checkbox"/> Knee <input type="checkbox"/> Shoulder <input type="checkbox"/> Hip <input type="checkbox"/> Other* <input type="checkbox"/> Left <input type="checkbox"/> Right
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\*Other (please specify) \_\_\_\_\_

**\*Patients with Pacemakers or Aneurysm clips will not be scanned.\***  
 If any of the checklist 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).

**MRI Exams - Complete The Checklist Below**

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

If so, please provide make, model, & serial number: \_\_\_\_\_

**2 CT Examination(s) Requested**

<p><b>Screening</b></p> <input type="checkbox"/> Virtual Colonoscopy <input type="checkbox"/> Coronary CT Angiography <input type="checkbox"/> Coronary Calcium Score <input type="checkbox"/> Whole Body CT (Chest, Abd, Pelvis)	<p><b>Body</b></p> <input type="checkbox"/> Pelvis <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Extremity* <input type="checkbox"/> Angiography	<p><b>Head &amp; Neck</b></p> <input type="checkbox"/> Routine Head <input type="checkbox"/> Orbits <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Facial Bones <input type="checkbox"/> Paranasal Sinuses <input type="checkbox"/> Temporal Bones <input type="checkbox"/> Angiography	<p><b>Spine</b></p> <input type="checkbox"/> Cervical (levels ) <input type="checkbox"/> Thoracic (levels ) <input type="checkbox"/> Lumbar (levels ) <input type="checkbox"/> SI Joints
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\*Other (please specify) \_\_\_\_\_

**CT Exams - Complete The Checklist Below**

<input type="checkbox"/> Pregnant	Y <input type="checkbox"/> N <input type="checkbox"/>
<input type="checkbox"/> Breast Feeding	Y <input type="checkbox"/> N <input type="checkbox"/>
<input type="checkbox"/> Renal failure / Myeloma / Pheochromocytoma	Y <input type="checkbox"/> N <input type="checkbox"/>
<input type="checkbox"/> Diabetes	Y <input type="checkbox"/> N <input type="checkbox"/>
<input type="checkbox"/> Taking Glucophage (Metformin)	Y <input type="checkbox"/> N <input type="checkbox"/>
<input type="checkbox"/> Previous allergies due to X-ray dye (Premedication regimen available on request)	Y <input type="checkbox"/> N <input type="checkbox"/>

**NOTE: MRI/CT patients with any of the following must have a serum creatinine within the last 90 days:**  
 ■ Over 70 years of age ■ Diabetic ■ Cardiac Disease  
 ■ Renal Disease ■ Hypertension

**3 Relevant History, Physical Findings, and Provisional Diagnosis**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Previous Relevant X-rays, Ultrasound, CT, MRI  No  Yes Where? \_\_\_\_\_ When? \_\_\_\_\_

**4 Referring Physician's Information**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Stamp  
& Practice ID

**URGENT FAX REPORT** (until 4 pm, M-F)  
 Copy To: Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_

## FREE PARKING AT ALL SITES

### \*\* ALL EXAMINATIONS \*\*

**Remember to bring the Imaging Requisition plus your Alberta Health Card and photo ID. 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.)**

### MRI Exam Prep

- All patients will complete a Patient Safety & Consent form that the technologist will review prior to scanning.
- Patients requiring an **MRI contrast** for enhanced studies will also complete an *MRI Contrast Consent* form.
- If the patient has had an injury to the eye with metal, they may require **orbit x-rays** prior to 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.

*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.*

### CT Exam Prep

- All patients will complete a Patient Information and Consent for Enhanced CT form.
- Patients requiring an injection of CT contrast for enhanced studies should be evaluated for renal function by the referring physician. A creatinine level may be required within 30 days prior to scheduling the exam if there is any question.
- If the patient is diabetic please call 780-444-5652 for instruction.
- Patients may be required to change into a patient gown depending on the examination type.
- Patients requiring an injection of CT contrast should have no solid food for 4 hours prior to the CT scan.

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

Brain  
Spine  
Extremities

Patient should not eat 1 hour prior to exam.

Chest  
Soft Tissue Neck  
Abdomen  
Pelvis

Patient should not eat or drink 4 hours prior to the exam. All patients for CT abdomen or abdomen and pelvis exams must arrive 45 minutes prior to their appointment to drink oral contrast.

Coronary CT  
Angiography

Read and follow CT contrast instructions above. No caffeine or exercise the morning of exam. Beta-blocker medication (Metoprolol) is necessary to slow your heart rate prior to the exam. Please take this as directed (usually 1 pill the night before and 1 pill the morning of the exam)

Virtual  
Colonoscopy

Two days before the exam, you will be provided with a kit that includes a low-fibre diet and medication to assist bowel cleansing. Simply follow the provided instructions and you are ready for the exam.

*\*Medications (except Glucophage/Metformin) may be taken as usual.*

*\*Diabetic patients taking Glucophage or Metformin must consult with their doctor prior to and after the CT scan appointment.*

### MEADOWLARK MRI & CT

200 Meadowlark Shopping Centre  
156 Street - 89 Ave  
Edmonton, AB T5R 5W9  
Ph: 780-444-5652 | F: 780-444-5642

*Please phone 780-669-2222 to schedule your appointment*

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