

MRI & CT Requisition

ALL REQUISITIONS ACCEPTED

We cannot perform an exam without your requisition

Central Booking
780-669-2222

Toll Free
1-866-771-9446

Fax
780-930-1593

Toll Free Fax
1-855-930-1593

Online
x-ray.ca/book-an-appointment

To cancel or rebook your appointment, please call Central Booking: Mon-Fri: 8AM-6:45PM, Sat: 9AM-4PM, Sun: Closed

Name: _____
Address: _____
Phone: _____ DOB: _____ Male Female Non-Binary
PHN: _____ Weight: _____ Date of LMP: _____

Appointment Details:
Date: _____
Time: _____
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>Neuro</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 *Other (please specify) _____ _____	<p>Extremity</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	<p>Body</p> <input type="checkbox"/> Breast <input type="checkbox"/> Prostate <input type="checkbox"/> Pelvis <input type="checkbox"/> Abdomen (To Crest) <input type="checkbox"/> Enterography <input type="checkbox"/> Liver Elastography <input type="checkbox"/> Liver Triple Screen <input type="checkbox"/> Full Body Screening
--	---	---

MRI Exams - Complete The Checklist Below

<input type="checkbox"/> Pregnant	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>Screening</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) *Other (please specify) _____ _____	<p>Body</p> <input type="checkbox"/> Pelvis <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Extremity* <input type="checkbox"/> Angiography	<p>Head & Neck</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>Spine</p> <input type="checkbox"/> Cervical (levels) <input type="checkbox"/> Thoracic (levels) <input type="checkbox"/> Lumbar (levels) <input type="checkbox"/> SI Joints
--	---	---	--

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.

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	No patient preparation required.
Chest Wall Breast	No patient preparation required.
Abdomen Kidneys/Liver Pancreas Pelvis Prostate Liver Elastography/ Triple Screen	Patient should not eat or drink 4 hours prior to the examination.

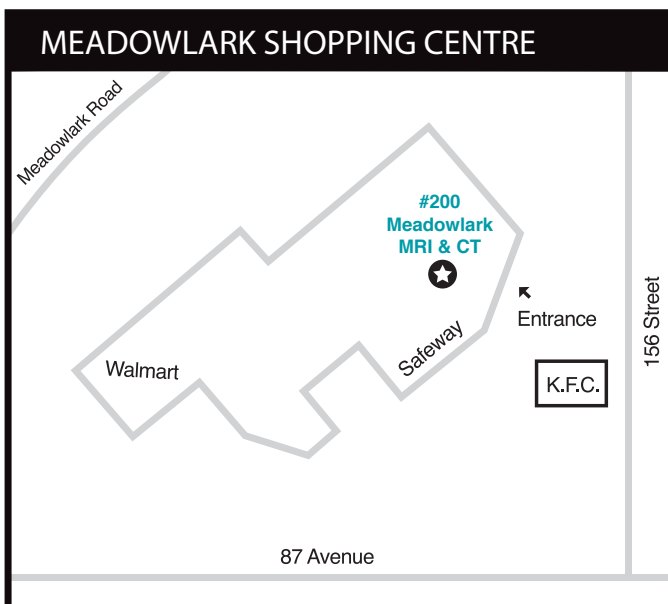
**Medications may be taken as usual.*

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*

FREE PARKING AT ALL SITES