IRM MRI+
CLINIQUE IRM PLUS
MRI PLUS CLINIC

DIAGNOSTIC MRI REQUISITION

Please fax the completed form to (819) 771-1311
or email to mri@mriplus.ca

Surname: First name:
Street address: Apartment no.:
City: Province: Postal Code:
Telephone # Home: Work:
Date of birth: /YY /MM /DD Sex: ☐ Male ☐ Female

File #:
Allergies:

	Yes	No
Patient pregnant:	☐	☐
Diabetic:	☐	☐
Breast implants:	☐	☐

Weight (kg):

Appointment
Date
Time

Examination required:

Research study:
Please specify study name
Yes ☐ No ☐

Chest/Abdomen
- ☐ Thorax
- ☐ Pelvis
- ☐ Abdomen & Pelvis
- ☐ Abdomen
  Specify Organ:

☐ Cardiac Function

Musculoskeletal
- ☐ Upper extremity:
  Specify:
- ☐ Lower extremity:
  Specify:
- ☐ Other:
  Specify:

Spine
- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar
- ☐ Total spine
- ☐ Other
  Specify:

Head and Neck
- ☐ Brain
- ☐ Sinuses
- ☐ Orbits
- ☐ Auditory canal (IAC)
- ☐ Neck
  Specify:

Other
- ☐ T-M joints
- ☐ MR - Angiography
- ☐ Aneurysm screening
- ☐ Neuro-vascular(MRI brain + MRA brain & neck)

☐ Breasts

Clinical information: (Please send copies of relevant report for studies requested)

MRI patient history (must be completed when requesting an MRI)

	Yes	No
Intracranial aneurism clip *	☐	☐
Cardiac pacemaker *	☐	☐
Intraocular lens implant/Prior metal fragment	☐	☐
Retinal detachment surgery *	☐	☐
Middle ear prosthesis *	☐	☐
Metallic heart valve prosthesis or cardiac pacerwires *	☐	☐
Filters/Stents/Coils	☐	☐

Specify **type** of filter, stent or coil and **date** of insertion

If patient has had open heart surgery please bring a copy of a recent chest X-Ray.
*** Attach copy of operative report**

Protocol:

Physician's name (Print): Digital Signature: Licence #:
Office Telephone # Fax # Pager #

Copy of report to:
Final Report in English ☐
Rapport final en français ☐
Preliminary report requested ☐
Fax # for report:

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