



PATIENT SCREENING INFORMATION

[In order to avoid time delays, please ensure that the following questions have been completed with the patient, prior to scheduling an appointment.]

PLACE MRI FILE # HERE

YES NO

1. Has the patient ever been a grinder, metal worker or welder?
2. Has the patient EVER had a metallic foreign body in their eye?
If yes, please provide an orbital x-ray report prior to appointment
3. Is there a chance the patient may be pregnant?
4. Does the patient have any of the following:
- Cardiac pacemaker?
 - Aneurysm clip?
 - Neurostimulator?
 - Cochlear implants?
 - Tattoos or body piercing or acupuncture needles?
 - Other implanted device(s) or metallic objects in body?
- Explain _____
5. Is the patient claustrophobic?
6. How much does the patient weigh? _____ lbs or _____ height
7. Has the patient had previous surgery? If yes, what type _____
_____ Date: _____

Protocol:

If the patient has answered YES to any of the above questions, the doctor's office should call Ottawa Valley MRI Centre before submitting this requisition.

Thank you.

PATIENT & REFERRING PHYSICIAN INFORMATION	Patient Name _____	Physician's Name: _____
	Address _____	Address _____
	City _____ Code _____	City _____ Code _____
	Tel. _____ Bus. _____ Fax _____	Telephone # (____) _____
	Birth Date: Yr ____ Mth ____ Day ____ <input type="checkbox"/> Female <input type="checkbox"/> Male	Fax # (____) _____
Additional Copies of Report to be sent to:		
Name _____ Address _____ City _____ Code _____		
Fax # _____		
MEDICAL HISTORY		
Area(s) to be examined: 1. _____ 2. _____ 3. _____		
Results of relevant examination:	Relevant surgical procedures:	

CLINICAL HISTORY

Physician's signature