MRI · CT

CANADA DIAGNOSTIC

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www.CanadaDiagnostic.com

☐ **CT** ☐ **MRI** ☐ **U/S** ☐ **Radiologist to decide**

Patient Name:

Address ____________________

City ____________ Code ____________

Tel ____________ Bus ____________

Birth Date: Yr ______ Mth ______ Day ______ ☐ Female ☐ Male

P.H.N. ____________________

Referring Physician:

Address ____________________

Tel ____________ Fax ____________

Additional Reports to be sent to:

Name ____________________

Fax ____________________

Name ____________________

Fax ____________________

Patient Questionnaire

Yes	No	Patient Questionnaire
		1. Height: ____________ Weight: ____________
☐	☐	2. Is there a chance the patient may be pregnant? Indicate date of last menstrual period ____________
☐	☐	3. Please list any previous surgery, including dates: ____________
☐	☐	4. Has the patient ever been a grinder, metal worker or welder?
☐	☐	5. Has the patient ever had a metallic foreign body in their eye? **If yes**, please provide an orbital x-ray report prior to appointment.
☐	☐	6. Does the patient have any of the following?: ☐ Cardiac pacemaker ☐ Cochlear implants ☐ Aneurysm clip ☐ Tattoos or body piercing ☐ Neurostimulator ☐ Stents ☐ Other implanted device(s) or metallic objects in body? Explain ____________
☐	☐	7. Is the patient claustrophobic?
☐	☐	8. Does the patient have allergies? If yes, please list ____________
☐	☐	9. Does the patient have diabetes mellitus? If yes, are they on Insulin? ______ On Metformin? ____________
☐	☐	10. Does the patient have a history of significant kidney disease? **If yes to #9 or #10, please indicate most recent serum creatinine** ____________
☐	☐	**11. Is the patient fully mobile?**

AREA(S) TO BE EXAMINED:

1. ____________ 2. ____________ 3. ____________

Results of relevant examination/surgical procedures. Please fax any previous reports.

Clinical History

____
Physician's signature

Protocol (for internal use only)

IV Contrast	☐ Yes	☐ No
Oral Contrast	☐ Yes	☐ No
	☐ Telebrix	☐ Water