



Referral Form CT MRI U/S

This form MUST be fully completed before an appointment is booked. Incomplete forms will be returned.

Patient
Patient Name
Address
City Code
Tel Bus
Birth Date: Yr Mth Day Female Male
P.H.N.

Doctor
Doctor Name
Address
City Code
Tel Fax

Additional Reports
Additional Copies of Report to be sent to:
Name
Address Fax
Name
Address Fax

Patient Questionnaire
Yes No
1. Is there a chance the patient may be pregnant? Indicate date of last menstrual period
2. How much does the patient weigh? lbs or kg
3. Has the patient had previous surgery? If yes, what type
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? Aneurysm clip? Neurostimulator? Cochlear implants? Tattoos or body piercing? Other implanted device(s) or metallic objects in body? Explain
7. Is the patient claustrophobic?
8. Has the patient had heart surgery? (Bypass, Bypass graft, Coronary graft, CABG, Stents)
9. Does the patient have allergies? If yes, please list
10. Does the patient have diabetes mellitus? If yes, are they on Insulin? On Metformin?
11. Does the patient have a history of significant kidney disease? If yes to #10 or #11, please indicate most recent serum creatinine
12. Is the patient fully mobile?

Examination Required
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)
Protocol IV Contrast Oral Contrast
Yes No
Yes No
Telebrix Water