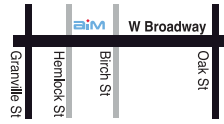


MRI Referral Form

TEL **604 733-4007**
FAX **604 734-2469**

1371 West Broadway,
Vancouver BC V6H 1G9

www.aimmedicalimaging.com
email:appointments@aimmedicalimaging.com



Underground Parking Available

"AIM for excellence"

Patient Information

NAME
First Surname

Date of Birth Male Female

Provincial Health Number

Address

Postal Code

Tel (H) Tel (W) Cell

Self Pay WCB ICBC RR

Safety Check

- Does the patient have a cardiac pacemaker? **Yes** **No** If "yes" - unable to proceed with scan
- Does the patient have an intracranial aneurysm clip or a programmable ventriculoperitoneal shunt? **Yes** **No** If "yes" - unable to proceed with scan
- Is there a risk of metallic foreign body in the patients eye? (ie metal worker) **Yes** **No** If "yes" - please order an orbit pre-MRI screening Xray & have the report cc'd to AIM
- Has the patient had a cochlear implant or neurotransmitter? **Yes** **No** If "yes" - unable to proceed with scan
- Does the patient have renal impairment? **Yes** **No** If "yes" - attach eGFR or creatinine labwork for contrast study, or contact AIM
- Has the patient had surgery in the last 8 weeks? **Yes** **No** If "yes" - unable to proceed with scan
- Does the patient have known or suspected communicable disease? (ie active Tb, MRSA, VRE) **Yes** **No** If "yes" - contact AIM

Area to be Scanned

Brain

Shoulder L..... R.....

Spine C..... T..... L..... **Knee** L..... R.....

Neuro

Sella

IACS

Orbits

MSK

Wrist L..... R.....

Ankle L..... R.....

Hip L..... R.....

SI Joint

Body

Abdomen.....

Pelvis

Other

History & List Previous Exams

Referrer NAME

Address

Postal Code

Tel (W) **Fax (W)**

Stamp

cc's

Signature

Date

Specialty / Profession
CPSID