aiM MEDICAL IMAGING
MRI CENTRE
"AIM for excellence"

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

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 .....
Spine C..... T..... L.....
Shoulder L..... R.....
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

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Referrer

NAME .....

Address .....

..... Postal Code .....

Tel (W) ..... Fax (W) .....

Stamp

cc's

Signature .....

Date .....

Specialty / Profession
CPSID .....