MRI REQUEST

O'Connor
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Patient Details

Name: .....

Address: .....

.....

DOB: ..... / ..... / ..... Contact no: .....

Medicare: ..... Exp Date: ..... / .....

Please Tick:

☐ Vet Affairs
☐ HCC / Pension
☐ MVIT

Worker's Compensation

Claim no: Insurer:

PAYMENT IS REQUIRED AT TIME OF CONSULTATION

EXAMINATION REGION FOR INVESTIGATION:

☐ Brain	☐ Pituitary	☐ Cervical Spine	☐ MRCP	☐☐ Shoulder	☐☐ Hip
☐ Brain + MRA	☐ Orbits	☐ Thoracic Spine	☐ Upper Abdo	☐☐ Elbow	☐☐ Knee
☐ Temporal Lobe	☐ IAM's	☐ Lumbar Spine	☐ Pelvis	☐☐ Wrist	☐☐ Ankle
		☐ Brachial Plexus	☐ Breast	☐☐ Hand	☐☐ Foot

Implants:
☐ Saline ☐ Silicone

Other:

CLINICAL DETAILS (must be included):

DIFFERENTIAL Dx (s):

Please Tick:

☐ Creatinine .....
☐ EGFR .....
☐ Allergies .....

Provider No: ..... Date: .....

Copies of reports to: 1..... Signature: .....

2 ..... Print Name: .....

"Your doctor has recommended that you use Apex Radiology. You may choose another provider but please discuss this with your doctor first."

MRI Safety Questionnaire and Body Map

Name: ..... DOB: ..... / ..... / .....

Weight: ..... Height: .....

Referrer's Name / Practice: .....

Certain Implants, devices and objects may be hazardous to you or may interfere with the MRI

Have you:		
Had a previous MRI?	☐ YES	☐ NO
If yes, when and where?		
Ever had an eye injury caused by metal?	☐ YES	☐ NO
If yes, was this removed by a doctor?	☐ YES	☐ NO
Had any operations in the last six weeks?	☐ YES	☐ NO
Are you pregnant or suspect you might be pregnant?	☐ YES	☐ NO
Do you have, or have you ever had:		
Cardiac pacemaker or Intra-Cardiac Defibrillator?	☐ YES	☐ NO
An artificial heart valve or wires?	☐ YES	☐ NO
Heart clips from cardiac surgery?	☐ YES	☐ NO
Aneurysm clips or coils?	☐ YES	☐ NO
Shunt in the brain or spinal cord?	☐ YES	☐ NO
Ear implant (Cochlear implant) or ear surgery?	☐ YES	☐ NO
Ocular Implant (Eye implant)?	☐ YES	☐ NO
Any implanted drug or other infusion pump?	☐ YES	☐ NO
A neurostimulator?	☐ YES	☐ NO
A bone growth stimulator?	☐ YES	☐ NO
An intra-uterine device (IUD)?	☐ YES	☐ NO
Any silver dressings?	☐ YES	☐ NO
Any pain patches or medication patches?	☐ YES	☐ NO
Removable plates / dentures?	☐ YES	☐ NO
Tattoo or permanent makeup?	☐ YES	☐ NO
Hearing aids?	☐ YES	☐ NO
Piercings / dermal piercings?	☐ YES	☐ NO
Hair extensions / wig / toupee?	☐ YES	☐ NO
Vascular stents, filters or coils? Where:	☐ YES	☐ NO
Any metal fragments or foreign bodies? Where:	☐ YES	☐ NO
Any other prosthesis, implants or devices? Please list:	☐ YES	☐ NO
Have you had any surgeries / operations in your lifetime? Please list:	☐ YES	☐ NO
Have you ever been diagnosed with cancer? Please specify:	☐ YES	☐ NO
Please describe your injury: What symptoms (IE pain) do you have at present?		

I acknowledge that to the best of my understanding the above answers are true and consent to the MRI examination.

Patient signature: ..... Date: ..... / ..... / .....

Person completing the form if not the patient: ..... Relationship: .....

STAFF USE ONLY:

☐ Correct Patient ☐ Correct Procedure ☐ Patient is MRI safe Radiographer initials: .....