

For appointments
please call
CENTRAL BOOKING
780-669-2222
Toll Free: 1-866-771-9446
Fax: 780-930-1593
*no appointment needed
for general x-ray



Meadowlark MRI
200 Meadowlark Health Centre
156 Street - 89 Ave
Edmonton, AB T5R 5W9
Phone: 780-444-5652
Fax: 780-444-5642

FREE PARKING

PLEASE FILL OUT COMPLETELY - an incomplete requisition may delay scheduling

NAME: _____ APPT. DATE: _____ TIME: _____

ADDRESS: _____ POSTAL CODE: _____

HOME PHONE: _____ WORK PHONE _____ DATE OF BIRTH: _____

MALE FEMALE Date of LMP: _____ DD/MM/YY _____ WEIGHT: _____ PHN: _____

THIRD PARTY PAYMENT: _____ WCB CLAIM NUMBER _____ DATE OF ACCIDENT: _____ DD/MM/YY _____

Private facility payment is due on completion of MRI Scan, except for Third Party Patients

Please keep your appointment. If you don't cancel 24 hours prior to exam, you may be charged a \$25.00 fee.
Remember that others with healthcare needs could use your appointment time.

MRI EXAMINATION(S) REQUESTED

Neuro:	Body:	Extremity:
<input type="checkbox"/> Brain	<input type="checkbox"/> Breast	<input type="checkbox"/> Knee
<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Chest Wall	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/> Abdomen (to crest)	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> Pelvis	
<input type="checkbox"/> Circle of Willis MRA	<input type="checkbox"/> Other (please specify) _____	

PHYSICAL FINDINGS, PROVISIONAL DIAGNOSIS & RELEVANT HISTORY

PREVIOUS RELEVANT X-RAYS, ULTRASOUND, CT, MRI No Yes Where? _____ When? _____

REFERRING PHYSICIAN'S NAME: _____ REFERRING PHYSICIAN'S SIGNATURE: _____

ADDRESS _____ POSTAL CODE: _____

PHONE: _____ FAX: _____

COPY TO: _____ PHONE: _____ FAX: _____

*MRI uses a strong magnetic field. Some metallic items may interfere with the imaging or be potentially hazardous.
Please complete the following checklist.*

YES NO

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Work with metal, including grinding or welding |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye injury with metal |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear and/or eye implant/prosthesis |
| <input type="checkbox"/> | <input type="checkbox"/> | Any type of heart surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker and/or pacer leads |
| <input type="checkbox"/> | <input type="checkbox"/> | Any type of brain or skull surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Any type of surgery in the past six weeks |
| <input type="checkbox"/> | <input type="checkbox"/> | Any type of stent, electrical or mechanical device/implant/prosthesis |
| <input type="checkbox"/> | <input type="checkbox"/> | Any metal in body |

Note: Patients with any of the following must have a serum creatinine WITHIN THE LAST 90 DAYS.

- Over 70 years of age
- Diabetic
- Renal Disease

If any of the above questions are marked "YES", we may need a recent x-ray prior to the MRI for the patient's safety.
(If x-rays are already completed, please send the report with this signed request.)

If there are any implanted devices please provide the make, model and serial number.

Patients with Pacemakers or Aneurysm clips will not be scanned.