



Patient First Name		Patient Last Name		Referring Physician Name	
Home Phone		Cell Phone		Phone Fax	
OHIP#	Version Code	Sex M F	DD / MM / YYYY	DD / MM / YYYY	
			Date of Birth	Date	

If through corporate/executive health; provide company name: _____ Phone _____ **48-hour notice required to cancel appointment or \$200 charge billed.**

DD / MM / YYYY
Appointment Date

Appointment Time

The patient has confirmed that the below studies are being performed strictly for screening purposes and not to evaluate a known medical condition or symptomatic issue.

STUDY TO BE PERFORMED - PLEASE CHECK ALL THAT APPLY

- WHOLE BODY MRI SCREENING EXAMINATION
- CORONARY CTA & CALCIUM SCORING
- CARDIAC CALCIUM SCORING
- PROSTATE MRI SCREENING
- BREAST MRI SCREENING (LOW RISK)
- BREAST IMPLANT MRI
- LIVER FAT QUANTIFICATION MRI

Doctor's Signature _____ Copy To: _____

LIST ALL SURGERY

Please list all surgeries and specify a date and type.

DD / MM / YYYY

DD / MM / YYYY

DD / MM / YYYY

Weight _____ Height _____

Date of last menstrual cycle

Date DD / MM / YYYY

FOR MRI PATIENTS

	YES	NO
Have you had a previous MRI?	<input type="checkbox"/>	<input type="checkbox"/>
Has metal ever gone into your eye?	<input type="checkbox"/>	<input type="checkbox"/>
Are you claustrophobic?	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to cadmium contrast?	<input type="checkbox"/>	<input type="checkbox"/>

DO YOU HAVE ANY OF THE FOLLOWING:

	YES	NO
Aneurysm Clips	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Cardiac Valve	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Cochlear Implants	<input type="checkbox"/>	<input type="checkbox"/>
Coil/Stents	<input type="checkbox"/>	<input type="checkbox"/>
Neurostimulator	<input type="checkbox"/>	<input type="checkbox"/>
Retained Pacing Wires	<input type="checkbox"/>	<input type="checkbox"/>
Shrapnel/Bullets	<input type="checkbox"/>	<input type="checkbox"/>

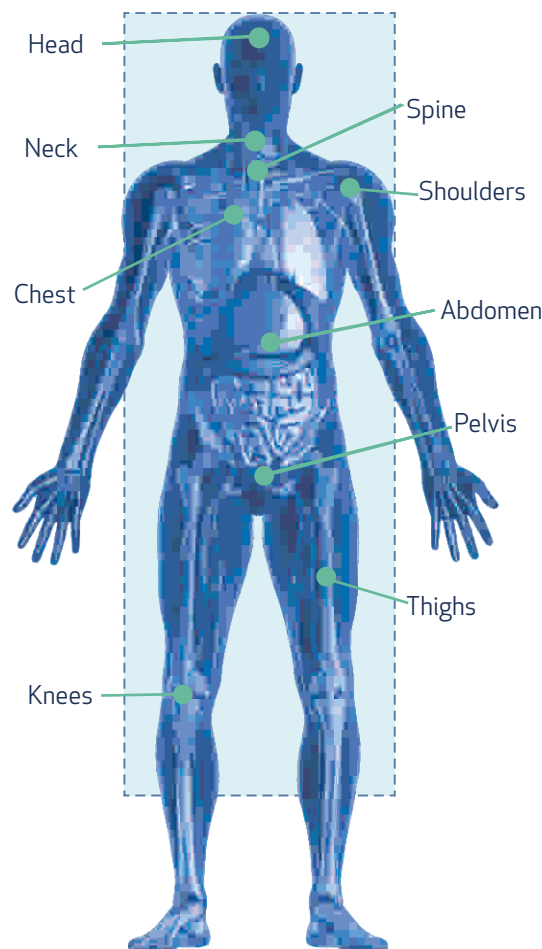
Other implanted devices _____

If YES to any, please specify (date, type, implant model):

FOR CT PATIENTS

	YES	NO
Previous reaction to IV contrast?	<input type="checkbox"/>	<input type="checkbox"/>

Area Covered By Whole Body MRI



Mississauga

The Emerald Centre
10 Kingsbridge Garden Circle
Mississauga ON L5R 3K6

Ajax/Pickering

Harwood Plaza
300 Harwood Avenue
Ajax ON L1S 2J1

FAX COMPLETED REQUISITIONS TO: (416)-572-8704

OR EMAIL TO: book@wholebodymri.ca

*Patient will be directly contacted to schedule an appointment