



Patient First Name _____		Patient Last Name _____		Referring Physician Name _____	
Home Phone _____		Cell Phone _____		Phone _____ Fax _____	
OHIP# _____		Version Code _____		Sex M F 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

- | | |
|---|--|
| <input type="checkbox"/> WHOLE BODY MRI SCREENING EXAMINATION | <input type="checkbox"/> PROSTATE MRI SCREENING |
| <input type="checkbox"/> CORONARY CTA & CALCIUM SCORING | <input type="checkbox"/> BREAST MRI SCREENING (LOW RISK) |
| <input type="checkbox"/> CARDIAC CALCIUM SCORING | <input type="checkbox"/> BREAST IMPLANT MRI |
| <input type="checkbox"/> DEXA | <input type="checkbox"/> 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

Have you had a previous MRI?	YES <input type="checkbox"/>	NO <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 gadolinium contrast?	<input type="checkbox"/>	<input type="checkbox"/>

DO YOU HAVE ANY OF THE FOLLOWING:

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

Previous reaction to IV contrast?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
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Area Covered By Whole Body MRI

