WHOLE BODY MRI

MY HEALTH MY LIFE

wholebodymri.ca
book@wholebodymri.ca

Phone: (647) 910-2639
Fax: (416) 572-8704

Patient First Name | Patient Last Name | Referring Physician Name

Email | Cell Phone | Phone | Fax

Address | Sex M | F | DD / MM / YYYY Date of Birth | Address

Email

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
- ❐ DEXA SCAN

Doctor's Signature ______ CC ______ Date ______

LIST ALL SURGERY

Please list all surgeries and specify a date and type

______
DD / MM / YYYY

______
DD / MM / YYYY

Weight ______ Height ______

Date of last menstrual cycle

Date DD / MM / YYYY

FOR CT PATIENTS

	YES	NO
Previous reaction to IV contrast?	❐	❐

If Yes, Describe the reaction ______

FOR MRI PATIENTS

	YES	NO
Have you had a previous MRI?	❐	❐
Has metal ever gone into your eye?	❐	❐
Are you claustrophobic?	❐	❐
Allergy to gadolinium contrast?	❐	❐

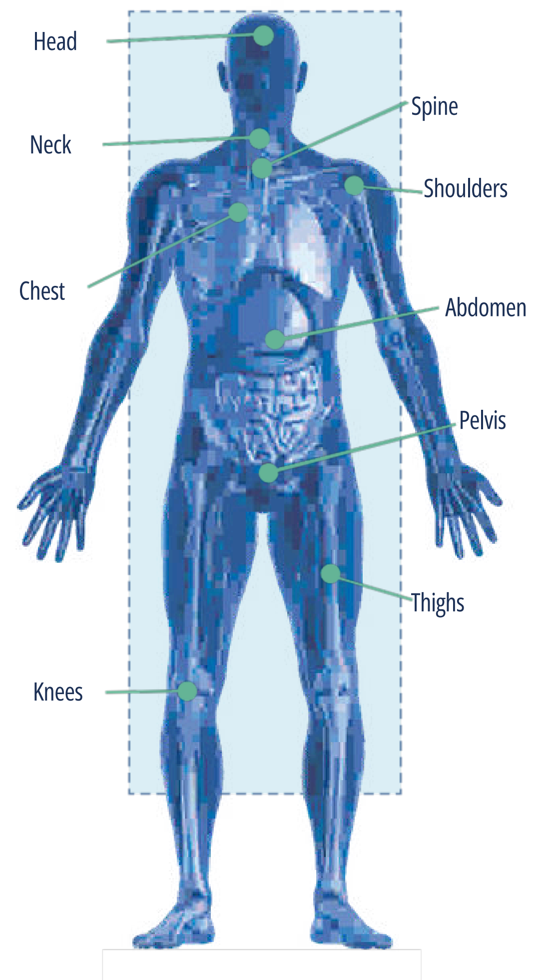
DO YOU HAVE ANY OF THE FOLLOWING:

	YES	NO
Aneurysm Clips	❐	❐
Artificial Cardiac Valve	❐	❐
Cardiac Pacemaker	❐	❐
Cochlear Implants	❐	❐
Coil/Stents	❐	❐
Neurostimulator /Retained Pacing Wires	❐	❐
Shrapnel/Bullets	❐	❐

Other implanted devices ______

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

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

St. Catharines
464 Welland Ave
St. Catharines
ON L2M 5V4

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

OR EMAIL TO: book@wholebodymri.ca

*Patient will be directly contacted to schedule an appointment