



Patient First Name	Patient Last Name	Referring Physician Name	
Email	Cell Phone	Phone	Fax
Address	Sex ☐ M ☐ F DD / MM / YYYY	Address	
If through corporate/executive health ; provide company name	Date of Birth	Email	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
- ☐ WHOLE BODY MRI LITE 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

Previous reaction to IV contrast?

YES NO

☐ ☐

If Yes, Describe the reaction

FOR MRI PATIENTS

Have you had a previous MRI?

YES NO

☐ ☐

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

☐ ☐

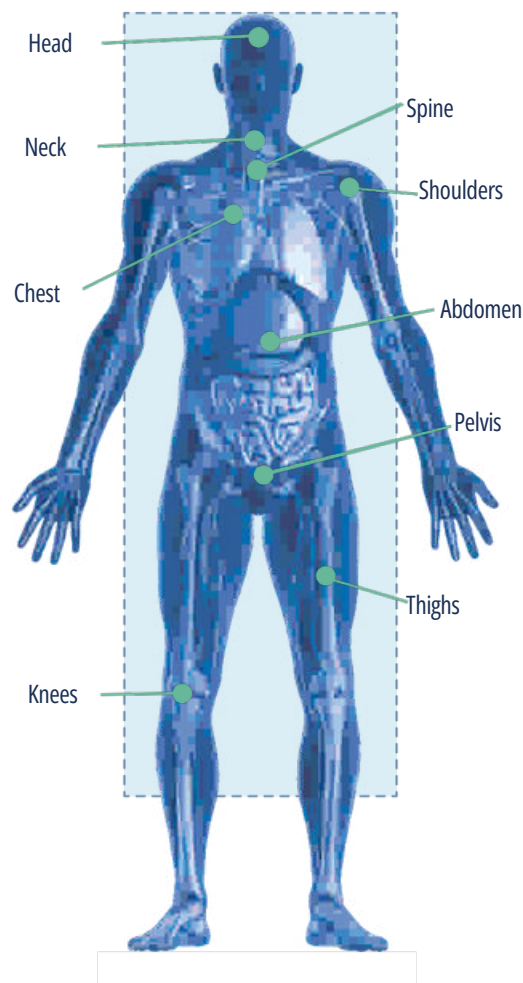
Shrapnel/Bullets

☐ ☐

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