



# Peace Regional MRI & Ultrasound

115 - 10200 8<sup>th</sup> St., Dawson Creek, BC, V1G 3P8 Tel. 250-784-0040

PLEASE SIGN AND COMPLETE  
MRI REQUISITION.

## MRI Requisition

**FAX TO:**  
**1-888-898-9857**  
OR  
**E-MAIL TO:**  
**orders@peacemri.com**

INCOMPLETE OR ILLEGIBLE  
REQUISITIONS WILL BE RETURNED.

### BODY PART TO BE EXAMINED:

- HEAD
- IACS
- TMJS
- SELLA
- ORBITS
- CERVICAL SPINE
- THORACIC SPINE
- LUMBAR SPINE
- SACRUM
- S/I JOINTS
- L/S PLEXUS
- NECK
- BRACHIAL PLEXUS
- CARDIAC
- LIVER
- MRCP
- PANCREAS
- KIDNEYS
- ENTEROGRAPHY
- PELVIS  
(including PROSTATE / UTERUS)
- WHOLE BODY SCREEN  
(SEE WEBSITE FOR DETAILS)
- MRA HEAD
- MRA CAROTIDS
- MRA AORTA
- MRA RENALS
- MRA RUNOFF  
Rt Lt Bilat Arthrogram
- SHOULDER
- ELBOW
- WRIST
- HAND
- HIP
- KNEE
- ANKLE
- FOOT

PATIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_

PROVINCE: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_

TELEPHONE (HOME): \_\_\_\_\_

TELEPHONE (MOBILE): \_\_\_\_\_

TELEPHONE (WORK): \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ HEIGHT: \_\_\_\_\_  
(MM/DD/YYYY)

MALE: \_\_\_\_\_ FEMALE: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

MSP: \_\_\_\_\_ WSBC: \_\_\_\_\_ ICBC: \_\_\_\_\_ RCMP: \_\_\_\_\_ MSP/CLAIM #: \_\_\_\_\_

HAS THE PATIENT HAD METAL FRAGMENTS IN THE EYE THAT  
HAVE NOT BEEN COMPLETELY REMOVED: NO YES

**IF "YES" PLEASE ORDER SCREENING X-RAY OF THE ORBITS AND FORWARD THE RESULTS.**

DOES THE PATIENT HAVE ANY IMPLANTED MEDICAL DEVICES  
(PACEMAKERS/ICDS, CEREBRAL ANEURYSM CLIPS, COCHLEAR  
IMPLANTS, NEUROSTIMULATORS, INFUSION PUMPS, ETC.): NO YES

SPECIFY TYPE: \_\_\_\_\_

IS THE PATIENT CLAUSTROPHOBIC, REQUIRING SEDATION: NO YES  
**IF "YES", PLEASE PRESCRIBE THE PATIENT AN ORAL SEDATIVE.**

IS THE PATIENT PREGNANT (DUE DATE, IF YES): NO YES

IF THE PATIENT REQUIRES MRI CONTRAST PLEASE  
ATTACH RECENT (<3 MONTHS) eGFR RESULTS: eGFR \_\_\_\_\_ DATE \_\_\_\_\_

**HISTORY / INDICATION / TENTATIVE DIAGNOSIS:**

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\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

REFERRING PHYSICIAN'S SIGNATURE \_\_\_\_\_ PRINT NAME \_\_\_\_\_ FAX REPORT TO #: \_\_\_\_\_

ADDITIONAL COPIES TO: \_\_\_\_\_

**PLEASE FORWARD ANY RELEVANT PREVIOUS IMAGING REPORTS PRIOR TO THE APPOINTMENT DATE.**

APPOINTMENT DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

*MRI DEPARTMENT USE ONLY*