PATIENT INFORMATION FORM

Today's date: D / M / Y	PATIENT FILE NUMBER:

PATIENT INFORMATION

Patient's last name:	First:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	NATIONALITY:

Sex:	Birth Date:	Age:	REPORT
❑ Male ❑ Female	D / M / Y		❑ COLLECTING BY HAND ❑ EMAIL: FILL IN EMAIL ADDRESS HERE

Address:	Home phone no.:

Mobile No:	Occupation	Place of Employment:

Insurance Provider:	Referring Doctor/Institution

Area to Scan	
1.	3.
2.	4.

IN CASE OF EMERGENCY

Name of relative or friend	Relationship to patient:	Home phone no.:	Work phone no.:

FOR ALEXANDRA MRI USE ONLY

CUSTOMER:

PRINTED IMAGES: ❑ YES ____________________ ❑ NO

CD ❑ ____________________ REPORT PRINTED ❑

FAXED: ❑ ________________ EMAILED: ❑ ________________

FRONT DESK:

❑CASH ❑CREDIT CARD ❑LINX

❑PRECERTIFICATION

INSURED BY: ______________________________

INSURANCE FORM ATTACHED: ❑ YES ❑NO

PAYMENT RECEIVED BY:______________________

1. Emailed to Doctor: ❑YES ❑ NO DATE: ______________________________.
2. REPORTING RADIOLOGIST: ____
3. INVOICE EMAILED: ____
4. PAYMENT RECEIVED: ______________________________ CHEQUE NO: ________________

MRI SAFETY QUESTIONNAIRE

NAME ______________________

DATE OF BIRTH ______ d/m/y

WEIGHT ______ lbs

HEIGHT ______ feet/inches

Please note: Certain implants, devices and objects may be hazardous to you or may interfere with the MRI

HAVE YOU:			
1	Had a previous MRI?	◯ Yes	◯ No
2	If yes, when and where?		
3	Ever had an eye injury caused by metal?	◯ Yes	◯ No
4	If yes has this been removed?	◯ Yes	◯ No
5	Had any operations in the last 6 weeks?	◯ Yes	◯ No
6	Are you pregnant or do you suspect you may be pregnant?	◯ Yes	◯ No

DO YOU HAVE, OR HAVE YOU EVER HAD:			
7	Cardiac Pacemaker or Intra-Cardiac Defibrillator?	◯ Yes	◯ No
8	An artificial heart valve or wires?	◯ Yes	◯ No
9	Heart Clips from Cardiac surgery?	◯ Yes	◯ No
10	Aneurysm Clips?	◯ Yes	◯ No
11	Shunt in Brain or Spinal Cord?	◯ Yes	◯ No
12	Ear implants (Cochlear implants) or ear surgery?	◯ Yes	◯ No
13	Ocular prosthesis (eye implant)?	◯ Yes	◯ No
14	Any implanted drug or other infusion pump?	◯ Yes	◯ No
15	A neurostimulator?	◯ Yes	◯ No
16	A bone growth stimulator?	◯ Yes	◯ No
17	An intra-uterine device (IUD)?	◯ Yes	◯ No
18	Removable plates/dentures?	◯ Yes	◯ No
19	Tattoo or permanent makeup?	◯ Yes	◯ No
20	Hearing aids?	◯ Yes	◯ No
21	Piercings?	◯ Yes	◯ No
22	Hair Extensions/wig/toupee?	◯ Yes	◯ No

Please turn over to complete questionnaire

23	Vascular stents, filters or coils? Where	○ Yes	○ No
24	Any metal fragments or foreign bodies? Where	○ Yes	○ No
25	Any joint replacements, orthopaedic pins/plates/screws? Where	○ Yes	○ No
26	Any other prosthesis, implants or devices? Please list	○ Yes	○ No
27	Have you every had any surgeries/operations in your lifetime? Please list ____________________	○ Yes	○ No
28	Have you ever been diagnosed with cancer? If Yes, Please specify	○ Yes	○ No
29	Please describe your injury, what symptoms (i.e. pain) do you have at present? ____________________ ____________________ ____________________		

I acknowledge that to the best of my understanding the above answers are true and hereby consent to the MRI examination (s).

Patient Signature ____________________ Date ____________________

Person completing form if not the patient ____________________ Relationship ____________________

STAFF USE ONLY:

Patient is MRI Safe: ○ YES ○ NO

Notes:

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Please turn over to complete questionnaire