228, St-Joseph Blvd, Suite 203
Gatineau QC J8Y 3X4
Tel.: 819 777-**1MRI** (1674)
Toll free: 1 877 677-**1MRI** (1674)
Fax: 819 777-7718
www.stjosephmri.com

***Your* MRI when *you* need it !**

Physician Referral Form

Please fax the completed form to (819) 777-7718

Name & Surname ______________________________

Maiden Name ______________________________ Date of Birth ____ / ____ / ____ (Y / M / D)

Address ______________________________

Home Phone (______) ______________________ Office (______) ______________________ Ext ______

Allergies ______________________________ Weight ________ ❑ KG ❑ LB.

Area to be scanned

Head and neck
- ❑ Head
- ❑ Sinuses
- ❑ Orbits
- ❑ Auditory canal (IAC)
- ❑ Neck

Details: ______________________

Spine
- ❑ Cervical
- ❑ Thoracic
- ❑ Lumbar
- ❑ Total spine
- ❑ Other:

Details: ______________________

Musculoskeletal
- ❑ Upper extremity:

Details: ______________________
- ❑ Lower extremity:

Details: ______________________
- ❑ Other:

Details: ______________________

Chest/Abdomen
- ❑ Chest

Specify the region of interest: ______________________
- ❑ Abdomen

Specify the region of interest: ______________________
- ❑ Pelvis

Specify the region of interest: ______________________

Breasts (both)
- ❑ Routine
- ❑ Staging
- ❑ Integrity of breast implants

Other
- ❑ Temporomandibular joints (TMJ)
- ❑ Vascular

Details: ______________________
- ❑ Screening

Details: ______________________

Contrast

❑ YES ❑ NO

(To be determined by the radiologist if not indicated.)

Patient Screening Information

In order to avoid any delay, please ensure that the following questions have been completed with the patient prior to scheduling an appointment.

Yes	No	
❑	❑	Has the patient ever been a grinder, metalworker or welder?
❑	❑	Has the patient ever had a metallic fragment in his/her eye?
❑	❑	Is there a chance the patient could be pregnant? Date of last menstrual period? ______________
		Does the patient have:
❑	❑	Cardiac pacemaker
❑	❑	Aneurysm clip
❑	❑	Neurostimulator
❑	❑	Cochlear implants/tube in the ears Myringotomy tube
❑	❑	Tatoos, body piercing
❑	❑	Transdermal patch
❑	❑	Vascular stent or vena cava filter
❑	❑	**Has the patient had previous surgery – cardiac or brain?** Details: ______________________
		Does the patient suffer from:
❑	❑	Claustrophobia
❑	❑	Kidney failure

Mandatory clinical information: ______________________

Presumptive diagnosis: ______________________

Previous pertinent tests/Where?

❑ MRI ❑ CT ❑ X-Rays ❑ US ❑ Nuclear Medicine

For Radiologist and Office Use

____

❑ Final report in French ❑ Final report in English Fax report to ______________________

Send ❑ CD ❑ Printout to ______________________

Ordering Physician ______________________ (Print name) / ______________________ (Signature)

Date ______________ Tel. ______________ Licence No. ______________