WHOLE BODY MRI
MY HEALTH MY LIFE

www.wholebodymri.ca
book@wholebodymri.ca
Phone: (647) 910-2639
Fax: (416) 572-8704

Patient First Name | Patient Last Name | Referring Physician Name

Home Phone | Cell Phone | Phone | Fax

OHIP# | Version Code | Sex M | F | DD / MM / YYYY Date of Birth | DD / MM / YYYY Date

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 this Whole Body MRI scan is being performed strictly for screening purposes and not to evaluate a known medical condition or symptomatic issue.***

STUDY TO BE PERFORMED

☐ WHOLE BODY MRI SCREENING EXAMINATION

Doctor's Signature _____ Copy To: _____

LIST ALL SURGERY

Please list all surgeries and specify a date and type.

DD / MM / YYYY

DD / MM / YYYY

DD / MM / YYYY

Weight _____ Height _____

Date of last menstrual cycle

Date DD / MM / YYYY

FOR MRI PATIENTS

	YES	NO
Have you had a previous MRI?	☐	☐
Has metal ever gone into your eye?	☐	☐
Are you claustrophobic?	☐	☐

DO YOU HAVE ANY OF THE FOLLOWING:

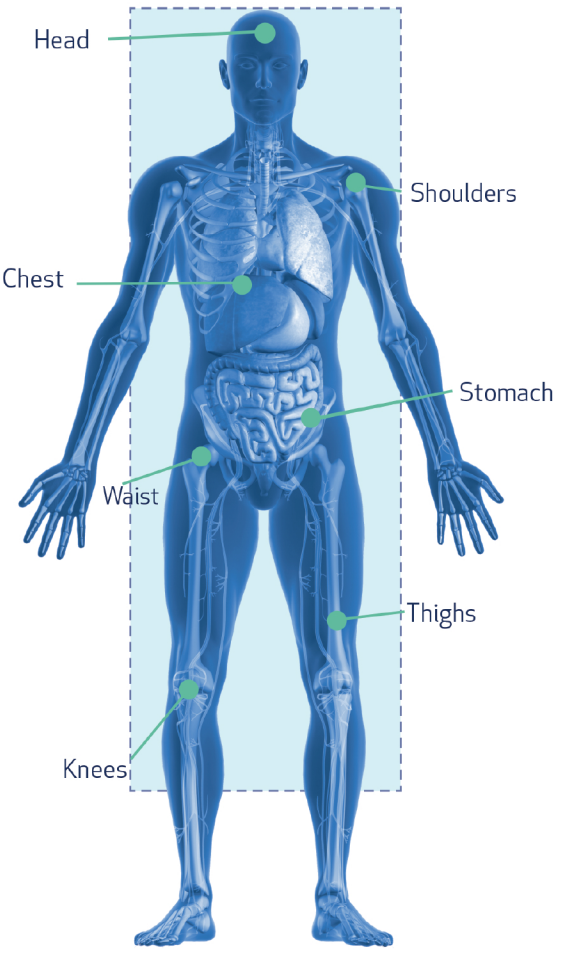
	YES	NO
Aneurysm Clips	☐	☐
Artificial Cardiac Valve	☐	☐
Cardiac Pacemaker	☐	☐
Cochlear Implants	☐	☐
Coil/Stents	☐	☐
Neurostimulator	☐	☐
Retained Pacing Wires	☐	☐
Shrapnel/Bullets	☐	☐

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

FAX COMPLETED REQUISITIONS TO: (416)-572-8704
OR EMAIL TO: book@wholebodymri.ca
*Patient will be directly contacted to schedule an appointment