Elysian Health

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MRI REQUISITION

SURNAME	FIRST NAME	SEX
ADDRESS		DATE OF BIRTH
CELL PHONE	HOME PHONE	PHN

☐ MRI ☐ MR ARTHROGRAM

EXAM REQUESTED:

RELEVANT HISTORY/INDICATION/ TENTATIVE DIAGNOSIS: (include relevant results from x-ray, CT, US, Angio, MRI, Nuclear Medicine)

DOES THE PATIENT HAVE ANY OF THE FOLLOWING?

Cardiac Pacemaker, Defibrillator	☐ YES ☐ NO
Cerebral Aneurysm Clip	☐ YES ☐ NO
Intervascular coil, stent, or Filter	☐ YES ☐ NO
Middle ear prosthesis/ cochlear/ staples/ implant	☐ YES ☐ NO
Shrapnel, Bullets, BB Pellets, or other metal fragments in the body	☐ YES ☐ NO
History as a metal worker	☐ YES ☐ NO
Metallic foreign body in the eye (ever in lifetime)	☐ YES ☐ NO
Neurostimulator	☐ YES ☐ NO
Kidney problems	☐ YES ☐ NO
Claustrophobia	☐ YES ☐ NO

Is patient: Pregnant ☐YES ☐NO Date of LMP: _____

History of contrast allergy to MRI or CT contrast? ☐ YES ☐NO (please specify)

Other ALLERGIES: _____

If patient requires intravenous contrast:

Recent eGFR (within 3 months): _____ Date: _____

Relevant Previous Imaging? ☐ YES ☐ NO Location: _____ Date: _____

Requesting Physician: _____ Signature: _____

MSP# _____ Phone: _____ Fax: _____

Additional copies to: _____ Fax: _____

Radiologist Protocol:	Tech Approval: