MAYFAIR® DIAGNOSTICS

MRI & CT REQUISITION

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Toll Free 1.877.4CT.4MRI
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Email booking@radiology.ca

PATIENT & APPOINTMENT INFORMATION

PLACE PATIENT LABEL HERE

Date of Request: D/ M/ Y/

Name: ☐ Female ☐ Male

Address:

City: Province: Postal Code:

Home Phone:

Other Phone:

Date of Birth: D/ M/ Y/

AHC #: WCB #:

Appt. Date: D/ M/ Y/ Time:

PRESUMPTIVE DIAGNOSIS

Area to be examined and history: (Please complete this section with as many details as possible. This enables our clinic staff to provide the most comprehensive patient care.)

Relevant previous exams.
Please submit images and reports.

CT HEALTH ASSESSMENT PACKAGES (Health assessment scans are not recommended routinely for patients under 40 years of age)

☐ **Mayfair ASSURANCE**
(Heart + Lung + Virtual Colonoscopy)1

☐ **Mayfair PREMIER**
(Heart + Lung + Abdomen/Pelvis (Contrast-Infused CT))2

1 **Recent serum creatinine required (<=90 days):**

☐ **Mayfair ESSENTIAL**
(Coronary CT Angiography + Virtual Colonoscopy)2
(Use CCTA requisition or we will follow up for further information)

☐ **Mayfair COMPREHENSIVE** (PREMIER + Virtual Colonoscopy)2

2 **Contrast-infused CT imaging requires clinical indication and recent serum creatinine (<=90 days):**

EXAM TYPE

☐ **MRI (Wide-bore)**

Diagnostic exam: (specify location)

Or choose from the following common exams:

☐ **Brain**
☐ **TMJ**
☐ **Cervical Spine** ☐ **Thoracic Spine** ☐ **Lumbar Spine**
☐ **Breast**
☐ **Abdomen** ☐ **Pelvis**
☐ **Joint:** (specify location) ☐R ☐L
☐ **Arthrogram**

Patient History – Check box if applicable:

☐ Claustrophobia
☐ Pregnant (LMP)
☐ Over 500 lbs.
☐ Cardiac pacemaker
☐ Coronary artery, heart valve surgery
☐ Aneurysm surgery or clip
☐ Inner ear implant
☐ Gunshot, metal fragment
☐ Eye/head metal foreign body3
☐ Welder, machinist, sheet metal worker3
☐ Endoscope (within the last year)

3 **Forward current orbit radiograph report.**

☐ **CT (Low-dose CT)**

Diagnostic exam: (specify location)

Or choose from the following common exams:

☐ **Heart** (Coronary Calcium Score)
☐ **Coronary CT Angiography***
☐ **Lung Screen**
☐ **Virtual Colonoscopy****

* **Recent ECG required (< 1 year)**

** **Recent serum creatinine required (<=90 days):**

☐ **PRP (Platelet Rich Plasma Injections)**

☐ **Prolotherapy**

(specify location)

HEALTHCARE PROVIDER'S INFORMATION

Referring Health Provider:

Signature:

Phone: Fax:

Copy to: ☐ WCB - Alberta

Address:

Practitioner's ID/Stamp:

☐ **Stat Report**

See reverse for examination instructions and location map.