

Surname: _____ First Name: _____ Date of Birth: _____

Address: _____ City: _____ Phone: _____

Province: _____ Postal Code: _____

WCB Claim Number: _____ PHN: _____ Third Party Payer: _____

MRI Exam

- Brain (Standard - Neurological Screening)
- Brain (IAC)
- Brain (MS)
- Brain (Positional H/A; Chiari Assessment - 2 Positions)
- Brain (Trauma)
- Brain (Seizure)
- Brain (MRI plus MRA)
- Brain (Tumor) + GAD
- Brain (Pituitary) + GAD

- Full CNS MS Exam (Brain & Full Cord)

- Soft Tissue Neck + GAD
- Cervical Spine (Flexion/Extension)

- Thoracic Spine (Standard - Single Position)

- Lumbar Spine (Flexion/Extension; Includes SI Joints)
- Lumbar Spine (Post-Op) + GAD**
- Lumbar Spine (Plus SI Joints - Multi Position) + GAD**
(For Ankylosing Spondylitis)

- SI Joints
- SI Joints + GAD
- Scoliosis
- Complete Spine (Multi Position Cervical, Thoracic, Lumbar)

- Single Hip Right
- Single Hip Left

- Pelvis
- Pelvic Floor

- Shoulder R L
- Elbow R L
- Wrist/Hand R L
- Single Hip R L

- Bilateral Hips (Weight Bearing & Non-Weight Bearing)
- Knee R L
- Ankle/Foot R L

- Shoulder Arthrogram R L
- Ankle Arthrogram R L

MR Angiography (MRA): MRA Brain (Aneurysm Screening)

MRA Carotids

Relevant History:

Relevant Prior Exam(s):

- MRI Nuclear Med X-Ray
- CT Mammogram

Date(s): _____

Location(s): _____

Creatinine & eGFR required within 30 days if client:

- is 70 years or older has hypertension
- is diabetic has severe hepatic disease
- has renal dysfunction

Creatinine: _____ mcmol/L

eGFR: _____ mL/min

Date: _____

Requesting Physician: _____ Copy Report To: _____

Address: _____ City: _____ Postal Code: _____

Province: _____ MSP: _____