Welcome Back
MRI and Pain Management Centre

MRI Requisition Form

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

Address: _____ **City** _____ **Phone: H:** _____ **C:** _____

_____ **Province** _____ **Postal Code** _____

WCB Claim # _____ **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 (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)
- ☐ Lumbar Spine (Post-Op) + GAD **

- ☐ SI Joints + GAD for ankylosing spondylitis
- ☐ Complete Spine (Multi Position Cervical, Thoracic, Lumbar)

- ☐ Single Hip – Right
- ☐ Single Hip – Left

- ☐ Bilateral Hips (Non-weight bearing)

- ☐ Pelvis

☐ Shoulder	☐ R	☐ L
☐ Elbow	☐ R	☐ L
☐ Wrist	☐ R	☐ L
☐ Knee	☐ R	☐ L
☐ Ankle	☐ R	☐ L
☐ Foot	☐ R	☐ L
☐ Shoulder Arthrogram	☐ R	☐ L

Relevant History:

Relevant Prior Exam(s):

- ☐ **MRI**
- ☐ **CT**
- ☐ **X-Ray**
- ☐ **Nuclear Med**
- ☐ **Mammogram**

Date(s): _____

Locations(s): _____

Creatinine & eGFR required within 30 days if client:

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

Creatinine: _____ **mcmol/L**
eGFR: _____ **ml/min**
Date: _____

Please Print Legibly

Requesting Physician: _____ **MSP #** _____

Address: _____ **City/Prov.** _____ **PC.** _____

Fax #: _____ **Copy report to:** _____

(Include Fax Number)

101-474 Columbia Street, Kamloops, BC V2C 2T5 **P:**250.828.6740 **TF:**1.866.759.2674 **F:**250.828.1423 info@welcomebackcentre.com

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