Whole Body MRI Imaging referral form

Patient Information

First name

Last name

Date of Birth

Male Female

Address

City and Province

Postal Code

Tel Home

Cell

Email

Insurance Information / PHN

Referring Medical Professional Information

First name

Last name

Stamp / Contact information

Specialty / Profession

License ID number

Signature

Date

Scan

Torso Head and Torso Whole Body

Reason for scan (mark below to avoid assessing GST)

- Family history of cancer or disease
- Previous cancer diagnosis
- Genetic risk of cancer or disease
- Fear of cancer or major illness
- Prior surgery or organ transplant
- Over 50, thus increased disease risk
- Persistently feel unwell or have pain with no explanation

Any Relevant Patient History

Safety Checklist

	Yes	No
Does the patient have a cardiac pacemaker?		
Does the patient have an intracranial aneurysm clip or a programmable ventriculoperitonel shunt?		
Is there a risk of metallic foreign body in the patient's eye? (eg. metal worker)		
Has the patient had a cochlear implant or neurotransmitter?		
Has the patient had a surgery in the last 8 weeks?		
Does the patient have a known or suspected communicable disease?		