MAYFAIR® DIAGNOSTICS

MRI & CT REQUISITION

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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 or WCB #:

Appt. Date: D/ M/ Y/ Time: ☐ am ☐ pm

PRESUMPTIVE DIAGNOSIS

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

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

☐ **Mayfair ESSENTIAL**
(Coronary CT Angiography + Virtual Colonoscopy) 2

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

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

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**
☐ **Body Composition Profile**

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 body 3
☐ Welder, machinist, sheet metal worker 3
☐ 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):**

REFERRER INFORMATION

Name:

Signature:

Phone: Fax:

Copy to: ☐ WCB - Alberta

Address:

Practitioner's ID/Stamp:

☐ **Stat Report**

See reverse for examination instructions and location map.