



## Extremity MRI Booking Requisition

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Prov: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Sex: \_\_\_\_\_ Wt: \_\_\_\_\_ Ht: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

*Please circle area to be examined:*

**RIGHT**

**LEFT**

**KNEE**

**ANKLE**

**FOOT**

**WRIST**

**ELBOW**

**HAND**

**Pertinent History / Symptoms:** \_\_\_\_\_

**Please indicate the presence of:**

1. Any surgically implanted device, for example, cardiac pacemaker, brain aneurysm clip, cochlear implant, (metallic, electronic or magnetic) None

2. Metal slivers in the eye(s) or injury to the eye(s) involving metal Yes  No

Referring Physician: \_\_\_\_\_

Physicians' Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Prov: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Copies to: \_\_\_\_\_

Office Use

Patient #: \_\_\_\_\_

WCB # \_\_\_\_\_

Lm: \_\_\_\_\_

Booked: \_\_\_\_\_

Protocol: \_\_\_\_\_