RADIANT MEDICAL SYSTEMS

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MRI REQUISITION

PATIENT INFORMATION

FIRST NAME	LAST NAME	DATE OF BIRTH (DD/MM/YYYY)

ADDRESS	PHONE (PRIMARY)	EMAIL

MOBILITY
☐ Ambulatory ☐ Wheelchair ☐ Assistance required

EXAMINATION REQUESTED

SIDE (IF APPLICABLE)
☐ Left ☐ Right ☐ Bilateral

PRIORITY
☐ Routine ☐ Semi-urgent ☐ Urgent

AREA TO BE EXAMINED	CLINICAL QUESTION TO BE ANSWERED

CLINICAL INFORMATION

ADDITIONAL CLINICAL HISTORY / PERTINENT FINDINGS (IF APPROPRIATE)

RELEVANT PRIOR IMAGING (TYPE, FACILITY, APPROX. DATE)	KNOWN MALIGNANCY?
	☐ No ☐ Yes: _____

PATIENT SAFETY SCREENING (REQUIRED FOR ALL MRI REQUESTS — CHECK ALL THAT APPLY)

- ☐ Cardiac pacemaker / ICD
- ☐ Aneurysm clip(s)
- ☐ Cochlear / otologic implant
- ☐ Implanted device / pump / stimulator
- ☐ Heart valve / stent / coil
- ☐ Metal fragments / metal-in-eye history
- ☐ Claustrophobia
- ☐ Pregnant / possibly pregnant
- ☐ Breastfeeding
- ☐ Renal disease / dialysis
- ☐ Insulin pump / CGM / wearable device
- ☐ Allergies / prior contrast reaction:

PREVIOUS SURGERY

REFERRING PROVIDER

NAME (PRINT)	LICENSE #	PHONE	FAX

COPIES OF REPORT TO (NAME + FAX)	SIGNATURE	DATE

FOR RADIANT OFFICE USE

DATE RECEIVED	SCHEDULED DATE / TIME	PROTOCOL	CONTRAST	ADMINISTERED BY
			☐ Y ☐ N	

Please fax or email this completed requisition with any relevant prior reports. Incomplete requisitions may delay booking.