

BOOKING PROTOCOL

- Physician office to fax to EFW Radiology
- EFW Radiology to confirm appointment with patient

MRI Booking **(403) 244-3700**
MRI Fax **(403) 210-8391**
Online Booking Request www.efwrad.com
3T and Wide Bore Options Available



Patient Information

Place patient label here

Name _____
 DOB DD/MM/YY Male Female _____
 Address _____
 City/Province _____ Postal Code _____

Phone (Home) _____
 Phone (Work) _____ Cell _____
 AHC# _____
 WCB# _____
 Height _____ Weight _____

CLINICAL HISTORY / QUESTION TO BE ANSWERED

Date of Issue DD/MM/YY _____

MRI

- Brain _____
- Soft Tissue Neck _____
- TMJ _____
- Cervical Spine _____
- Thoracic Spine _____
- Lumbar Spine _____
- SI Joints _____
- Breast _____
- Abdomen _____
- Pelvis _____
- Prostate _____
- Joint (Specify Location) _____
 R L Arthrogram
- Other _____

MRI PATIENT SAFETY INFORMATION

	Yes	No
Pacemaker and/or cardiac defibrillator?	<input type="checkbox"/>	<input type="checkbox"/>
Ear or eye implant?	<input type="checkbox"/>	<input type="checkbox"/>
Intracranial aneurysm clip?	<input type="checkbox"/>	<input type="checkbox"/>
Heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Penetrating metal eye injury?	<input type="checkbox"/>	<input type="checkbox"/>
Was it removed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>
Renal function normal?	<input type="checkbox"/>	<input type="checkbox"/>
Creatinine _____		
Claustrophobic?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, physician ordered sedation advised</i>		
Any chance of pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
Breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>
Last menstrual period? _____		

Please provide surgical report, make model and serial # for all implanted devices or stents.

PREVIOUS RELEVANT EXAMS

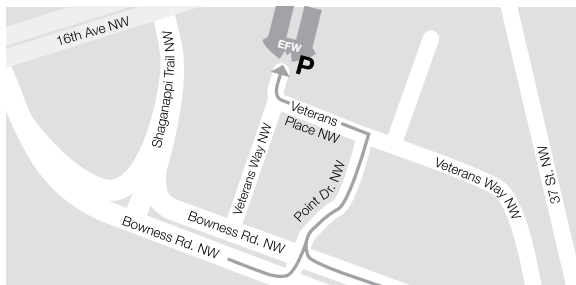
Exam	Yes	When	Where
MRI	<input type="checkbox"/>	_____	_____
CT	<input type="checkbox"/>	_____	_____
X-ray	<input type="checkbox"/>	_____	_____
US	<input type="checkbox"/>	_____	_____
Nuclear Medicine	<input type="checkbox"/>	_____	_____
Other _____			

REFERRING PHYSICIAN

Physician Name: _____
 Signature: _____
 Additional report to: _____
 Call/Fax emergency report to: _____
 Physician Phone: _____
 Physician Address: _____

PATIENT INSTRUCTIONS

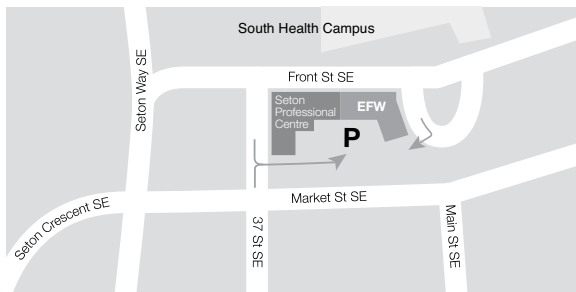
- Please arrive 30 minutes in advance of your appointment time unless otherwise indicated by MRI booking clerk.
- Confirming your identification is essential to ensure accurate medical records and for your protection and security.
- You will be asked at EACH VISIT to provide a VALID HEALTH CARE CARD and PICTURE ID.
- If you do not have your Health Care card you may be asked to return for your examination.
- Please bring your requisition with you, if it is not already on file with EFW Radiology.
- 24 hour notice required for appointment cancellations.
- Patients suspecting pregnancy should consult their physician before exam date.
- If you are having an **Abdominal or Pelvic MRI**, you **MAY NOT eat or drink for 6 hours before your appointment**. You may however take all prescribed medications with minimal amounts of water.
- If you are breastfeeding and require an injection of contrast with your MRI exam, you must inform the MRI Technologist prior to your appointment.
- Please arrange for child care as your children cannot accompany you into the MRI room.



EFW Radiology - Cambrian

#100, 2000 Veterans Place NW
Calgary, AB T3B 4N2

Located on the 1st floor of the Cambrian Wellness Centre. Complimentary underground parking is available. Please register your vehicle plate with reception on the day of your appointment.



EFW Radiology - Seton

#116, 3883 Front Street SE
Calgary, AB T3M 2J6

Complimentary underground and above ground parking available in designated EFW Radiology stalls. Please register your vehicle plate with reception on the day of your appointment. Parking in non-designated EFW stalls will not be reimbursed.

Official diagnostic imaging provider for:



EFW is a proud partner of:



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www.efwrad.com

SEPARATE REQUISITIONS FOR:

General Diagnostic, Pediatric Ultrasound, or Pain Management & Spine Interventional

Available as PDF downloads are available:

Online: www.efwrad.com Call: **(403) 717-1816**

The personal health information that you provide to EFW is collected, used and disclosed in accordance with the provisions of the Health Information Act (HIA), and is used to provide diagnostic, treatment and care services to you, and to bill Alberta Health Care for services provided. For more information, please contact the EFW Privacy Officer at (587) 470-6449.