PATIENT INFORMATION FORM

TODAY'S DATE: D / M / Y

PATIENT INFORMATION

PATIENT'S LAST NAME:	FIRST:		
		❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.

SEX:		BIRTH DATE:	NATIONALITY:
❑ Male	❑ Female	D / M / Y	

REPORT

❑ COLLECTING BY HAND

❑ EMAIL: ______________________________

MOBILE NO	HOME PHONE NO.	ADDRESS

OCCUPATION	REFERRING DOCTOR/INSTITUTION

IN CASE OF EMERGENCY

NAME OF RELATIVE OR FRIEND	RELATIONSHIP TO PATIENT:	HOME PHONE NO.:	WORK PHONE NO.:

HOW DID YOU HEAR ABOUT ALEXANDRA MRI?

DIGITAL BILLBOARD ❑ BROCHURES ❑ STATIC BILLBOARD ❑

REFERRED BY DOCTOR ❑ ANOTHER PATIENT ❑ OTHER ❑ ______________________

WHAT MADE YOU CHOOSE OUR FACILITY?

OPEN MRI ❑ REFERRED BY DOCTOR ❑ LOCATION ❑ OTHER ❑ ______________________

FOR ALEXANDRA MRI USE ONLY

CUSTOMER:

PRINTED IMAGES: ❑ YES ______________ CD: ❑ YES ______________

EMAILED TO PATIENT: ❑ YES ______________

FAXED: ❑ ______________

EMAILED: TO DOCTOR ❑ ______________________

FRONT DESK:

❑CASH ❑CREDIT CARD

❑LINX ❑CHQ # ______________

❑PRECERTIFICATION

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PLEASE TURN OVER TO COMPLETE QUESTIONAIRE

#4A Alexandra Street, St. Clair Tel: 225 -AMRI (2674)

MRI PATIENT SAFETY QUESTIONNAIRE

Please answer the following Questions:

QUESTION		YES	NO	DETAILS
DO YOU HAVE, OR HAVE YOU EVER HAD:				
Previous MRI?				
Pacemaker Fitted?				
Heart Surgery or Heart Valve Replacement?				
Operations to your Eyes, Ears, Head or Spine?				
Brain Hemorrhage?				
Aneurysm Clip?				
Cardiac Stents implanted in your Heart?				
Artificial Implanted Devices? Including: artificial joints, limbs, pins, plates, stents, filters, hydrocephalus shunts, eye implants, coils.				
Any Metal Injury to your Eyes? When?				
Skin Patch / Tattoos?				
Dentures, Hearing Aids, Wig?				
Allergic Reaction to Anything?				
Any Kidney Problems?				
Female Patients	Pregnant or suspect to be?			
	Are you breast feeding?			
What is your Weight?				
For ALL Patients				

You will need to REMOVE ALL Metallic Objects

e.g. watch, jewellery, fire arm, credit cards and coins.

Please remove ALL items from your pockets.

I CONFIRM ALL THE ABOVE INFORMATION I HAVE GIVEN IS CORRECT

PATIENT SIGNATURE: ______________________________ Date: ________________________

ON BEHALF OF PATIENT: ______________________________ Date: ________________________

RADIOGRAPHER'S SIGNATURE ______________________________ Date: ______________________