Please adhere Patient Label
PATIENT DETAILS:

MRI Scan Form
Form IC/01[1d]

matilda
International Hospital
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MRI Scan Request Form

(All jewelry & body piercing must be removed before attending an MRI appointment)

Date of Exam:_____ **Time :** _____ ☐ **Plain Study** ☐ **With & Without Contrast** ☐ **Contrast Optional**

Head & Neck

- ☐ Orbits
- ☐ Nasopharynx
- ☐ Larynx
- ☐ Temporomandibular Joint: (☐Right ☐Left)
- ☐ Paranasal Sinus
- ☐ Pharynx
- ☐ Neck

Neuro & Spine

- ☐ Stroke Package* [MRI Brain (Non contrast), DWI, MRA Brain & MRA Neck]
- ☐ Brain
- ☐ IAM: (☐Right ☐Left)
- ☐ Cervical Spine
- ☐ Lumbar Spine (L1 to S1)
- ☐ Whole Spine Screening [Sagittal Scan Only]
- ☐ Brain + Brain Stem
- ☐ Sella & Pituitary
- ☐ Thoracic Spine
- ☐ Sacrum
- ☐ Lumber Spine+Sacrum (LS Spine)

MR Angiogram

- ☐ Circle of Willis (MRA Brain)
- ☐ Renal
- ☐ Carotid
- ☐ Aorta: Thoracic / Abdominal
- ☐ Abdominal Artery
- ☐ Pulmonary Artery
- ☐ Lower Limbs Arteries

Others:

- ☐ Other Region _____

Body

- ☐ Thorax
- ☐ Abdomen (from top of diaphram to aortic bification)
- ☐ Whole Abdomen (Abdomen & Pelvis)
- ☐ Pelvis
- ☐ MR Urogram
- ☐ Prostate: Supra pubic coil
- ☐ Hypertensive Package#
- ☐ MRCP
- ☐ Breast: (☐Right ☐Left)
- ☐ Whole Body Screening (Excluding Limbs)

[MRA Renal Artery, MRI Kidney & MRI Adrenal]

Musculo Skeletal System

- ☐ Shoulder (☐Right ☐Left)
- ☐ Elbow (☐Right ☐Left)
- ☐ Wrist (☐Right ☐Left)
- ☐ Hip (☐Right ☐Left)
- ☐ Knee (☐Right ☐Left)
- ☐ Fore foot(☐Right ☐Left)
- ☐ Foot + Ankle(☐Right ☐Left)
- ☐ Ankle (☐Right ☐Left)

Cardiac Packages

- ☐ Cardiac Anatomy, Function, Myocardial Viability, Stress & Rest Myocardial Perfusion
- ☐ Anatomy & Function ☐(Right venticle) ☐(Left venticle)
- ☐ Myocardial Viability
- ☐ Stress Myocardial Perfusion with Adenosine

Clinical Data & Diagnosis

(Please bring along old films and/or report for comparison)

Standard Precaution	☐
Contact Precaution	☐
Droplet Precaution	☐

Medical History

(If "Yes", please tick the appropriate item(s) below):

- ☐ Claustrophobia
- ☐ Cardiac Pacemaker
- ☐ Metallic Implant
- ☐ Ocular Metallic Foreign Body
- ☐ Aneurysm Clips
- ☐ Neuro Stimulators
- ☐ Middle Ear Prosthesis
- ☐ Heart Valve Prosthesis
- ☐ Intravascular Stent, Model ____
- ☐ History of Hypertension
- ☐ History of Diabetes Mellitus
- ☐ History of Heart Disease
- ☐ Heart Block
- ☐ History of Allergies
- ☐ History of Asthma
- ☐ Previous Operation Pls State: _____
- ☐ Previous Contrast Reaction Pls State: _____

For Contrast Study Only:

- ☐ For patients aged ⩾60 years, please provide renal function: Creatinine:_____umol / L Urea:_____umol / L

☐ CD ☐ FILM

Department Use:

MRI No.:

Operator:

Radiologist / Cardiologist:

Body Weight

Bill Doctor ☐ **Bill Patient** ☐

Signed & Print Dr's Name: _____