



MRI Patient Requisition & Fax Form

Please fax completed form to Canadian Magnetic Imaging at 604.733.4424

Patient Information:

Patient Name: _____ Phone Res: _____

Address: _____ Phone Work: _____

_____ Phone Cell: _____

Age: _____ Date of Birth: _____ Sex: _____ Weight: _____
(Day/Month/Year)

History/Symptoms: _____

Area to examine: _____

Looking for: _____

Referring Practitioner: _____ Phone: _____ Fax: _____

Practitioner's Address: _____

City: _____ Province: _____ Postal Code: _____

Referring Practitioner's Signature

Please send any prior MRI, CT or X-ray exams and reports related to this condition.