

High Field 1.5 Tesla Wide-Bore MRI Clinic in the Hycroft Center, Vancouver

The CMI Advantage

Clinical Perspective – Uncompromised Diagnostic Confidence

- Utilizing leading edge, high field, open-bore technology with the 1.5 Tesla Siemens Magnetom Espree
- Established protocols for a broad array of specialized exams including Whole Body, Susceptibility Weighted Imaging (Mild Traumatic Brain Injury) and MR Enterography
- A team of three multi-disciplinary Radiologists from St. Paul's Hospital
- The only clinic in BC offering truly contingent litigation scans so that if the patient does not recover from their insurer, the scan is free

Patient Perspective – Revolutionary Openness & Comfort

- Large Wide-bore design (2.4 feet) allowing twice the head space of traditional, vertical-field magnets
- More than 60% of the exams are performed with the patient's head outside of the magnet significantly reducing patient anxiety & claustrophobia
- Can accommodate patients up to 550 lbs

The Referral Process

CMI accepts referrals from all licensed BC physicians

- Simply fill out & sign the attached Requisition Form and **fax to (604) 733-4424**
- Upon receipt of the Requisition, a CMI representative will contact the patient to schedule an appointment
- Nonexistent wait list - Appointments can be made within 24-48 hours
- A full report will be sent to you within 2-3 business days

Online Communication System (P.A.C.S.)

- CMI's state-of-the-art Picture Archive Communications System (P.A.C.S.); a web-based system that allows for immediate access to your patients images & reports from the convenience of your office, clinic or home



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 Physician: _____ Phone: _____ Fax: _____
Physician's Address: _____
City: _____ Province: _____ Postal Code: _____

Referring Physician's Signature

Please send any prior MRI or CT exams and reports related to this condition.