WorkSafe
WORKERS' COMPENSATION BOARD OF BC

Mailing Address: PO Box 5350 Stn Terminal, Vancouver BC V6B 5L5
Location: 6951 Westminster Highway, Richmond BC
Telephone 604 214-6700, Fax 604 276-3195 or 1 888 922-3299

REQUEST FOR MAGNETIC RESONANCE IMAGE (MRI) CONSULTATION

Visiting Specialists' Clinic & Diagnostic Imaging Records

DOCTOR TO COMPLETE. INCOMPLETE REQUESTS WILL BE RETURNED.

Worker's last name *Mr. Miss Mrs. Ms.*			Claim number
First name(s)		GENDER ❒ Male ❒ Female	Worker's Personal Health Number from BC CareCard
Mailing address			Date of birth *Month Day Year*
City	Postal code		Phone number Home ( ) Work ( )

RELEVANT PREVIOUS FILMS

XRAY
Date ______
Location ______

ULTRASOUND
Date ______
Location ______

CT SCAN
Date ______
Location ______

MRI SCAN
Date ______
Location ______

RENAL FUNCTION ABNORMAL?
Creatinne ______

ALLERGY/ASTHMA/HAYFEVER?
Specify ______

IS THE PATIENT
Pregnant? ❒ Yes ❒ No
Claustrophobic? ❒ Yes ❒ No

IS SEDATION REQUIRED?
❒ Yes ❒ No
If YES, please prescribe sedation

PATIENT'S WEIGHT

TRANSLATOR REQUIRED?
❒ Yes ❒ No

Exam requested

Tentative diagnosis

Relevant history/reason for exam *(include any medications)*

Essential pre-examination information for patient safety — known implanted metal or device. If YES, please explain.

	Yes	No	
Cerebral aneurysm clip	❒	❒	Type ______
Cardiac pacemaker or other electronic device	❒	❒	Type ______
Artificial heart valve	❒	❒	Type ______
Neuro stimulator	❒	❒	______
Middle ear prosthesis	❒	❒	______
Orbital foreign body	❒	❒	______
Metal worker (at any time)	❒	❒	______
Shrapnel, bullet	❒	❒	______
Orthopedic device	❒	❒	______
Harrington rod	❒	❒	______
Swan Ganz catheter	❒	❒	______
Venous access device	❒	❒	______
Other	❒	❒	______

Authorizing physician *(please print name)*	Signature of authorizing physician MD	Billing number
WCB authorization *(please print name)*	Signature of WCB authorization	
Please fax copy of report to WCB at 604 276-3195 or toll free 1 888 922-3299.	Additional copy to *(i.e. specialist/family physician)*