This form is to be completed prior to booking the MRI by the referring physician. Please send with requisition to allow appointment to be booked appropriately.

Date of Examination:______________________

Relevant History

1. Past Health  
   ........................................................................................................................................................................

2. Condition Requiring MRI  
   ........................................................................................................................................................................

Physical Examination

3. ENT & Airway:  
   □ snoring  □ drooling  □ enlarged tonsils  □ apnea  
   □ blue spells  □ GERD  □ home O² therapy  □ other______________________

   Chest:  
   □ asthma  □ reactive airway  □ inhalers  □ other_____________________

   Cardiovascular:  
   □ heart murmur  □ ECG/ECHO reports  
   Cardiologist’s name and number:____________________________________________________

   Musculo/Skeletal:  
   □ hypotonia  □ headlag  □ cervical abnormalities  □ other____________________

   Neurological:  
   □ seizures  

Additional Medical Notes  
   ........................................................................................................................................................................

Specific Requirements

Please provide details pertaining to the following medical issues:

4. Was the child a premature baby?  
   □ yes  □ no  
   If yes, how many weeks?

5. Is the child diabetic?  
   □ yes  □ no

6. If the patient is of Caribbean/African descent, they must be tested for Sickle Cell. Results are to be submitted with requisition.

7. If patient in under 6 months of age, recent Hbg must be submitted with requisition.

Completed by: Physician’s name:______________________ Signature:_____________________ Date_________________