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| LOGO    **THE HOSPITAL** FOR SICK CHILDREN **Request for Magnetic Resonance Imaging (MRI)** | |  | | | | | |
| **MRI Contact information**  Tel: (416) 813 – 5774 Fax: (416) 813 – 5789  **Phone** **department if emergent or urgent** | |
| **1. Will the patient be able to be cooperative and remain still for about 60 min?** ❑Yes❑No  **If not,** the patient may require sedation or general anesthesia. | |
| **Weight:** | | | | | |
| **2. Exam requested** (all parts to be examined)  **Relevant previous imaging: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Imaging done in❑SickKids ❑ Outside institution | | **Initial MRI Screening:** | | | | | |
| Aneurysm clip  Embolisation coils  Inner ear implant  Neuro/biostimulator  Implant  Braces  Pregnant  Details : | Y ❑ N ❑  Y ❑ N ❑  Y ❑ N ❑  Y ❑ N ❑  Y ❑ N ❑  Y ❑ N ❑  Y ❑ N ❑ | | | Intraventricular shunt  Programmable shunt  Hx of penetrating eye injury  Metal prosthesis  Implanted drug infusion  Unable to lie flat  Any surgery including dental  Date of previous surgery: | Y ❑ N ❑  Y ❑ N ❑  Y ❑ N ❑  Y ❑ N ❑  Y ❑ N ❑  Y ❑ N ❑  Y ❑ N ❑  \_\_\_\_\_\_\_\_\_\_ |
| **3. History and indications for exam** (working or known diagnosis, symptoms, clinical findings) | | | | | | | |
| **4. Additional relevant history and comments**  Cardiac anomaly Y ❑ N ❑ Family Hx of malignant hyperthermia Y ❑ N ❑  Respiratory/airway problems Y ❑ N ❑ Neck instability Y ❑ N ❑  Allergies Y ❑ N ❑ Other Y ❑ N ❑  Previous reaction to contrast Y ❑ N ❑ Provide details if you answered “Yes” to any Diabetic Y ❑ N ❑ of the questions:  Metabolic Y ❑ N ❑  Renal disease Y ❑ N ❑  Sickle cell disease Y ❑ N ❑ | | | | | **5. Preferred date of exam:**  Elective Y ❑ N ❑  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of O.R. if pre-procedure exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If follow-up please state time interval desired: | | |
| 6. Responsible physician Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Department at SickKids: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pager #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_ 7. Ordering clinician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
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| DI USE ONLY **Comments:** | | | | | | | |
| **Urgency**  ❑ Emergent (<24 hours)  ❑ Inpatient or Urgent (<2 days)  ❑ Semi-Urgent (<10 days)  ❑ Elective  ❑ Specified time procedure  Radiologist’s initial: | **Protocol:**  Radiologist initials: | | | Booking Clerk Date received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Letter sent (date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Clinic notification date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Family notification date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |