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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 clipEmbolisation coilsInner ear implantNeuro/biostimulatorImplantBracesPregnantDetails :  | Y ❑ N ❑Y ❑ N ❑Y ❑ N ❑Y ❑ N ❑Y ❑ N ❑Y ❑ N ❑Y ❑ N ❑ | Intraventricular shuntProgrammable shuntHx of penetrating eye injuryMetal prosthesisImplanted drug infusionUnable to lie flatAny surgery including dentalDate 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 physicianPhysician 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 procedureRadiologist’s initial: | **Protocol:** Radiologist initials: | Booking ClerkDate received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Letter sent (date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Clinic notification date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Family notification date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |