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

ADDRESSOGRAPH

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	Y ❑	N ❑	Intraventricular shunt	Y ❑	N ❑
Embolisation coils	Y ❑	N ❑	Programmable shunt	Y ❑	N ❑
Inner ear implant	Y ❑	N ❑	Hx of penetrating eye injury	Y ❑	N ❑
Neuro/biostimulator	Y ❑	N ❑	Metal prosthesis	Y ❑	N ❑
Implant	Y ❑	N ❑	Implanted drug infusion	Y ❑	N ❑
Braces	Y ❑	N ❑	Unable to lie flat	Y ❑	N ❑
Pregnant	Y ❑	N ❑	Any surgery including dental	Y ❑	N ❑
Details :			Date of previous surgery:	__________	

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 of the questions:		
Diabetic	Y ❑	N ❑			
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: ____________

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: _________________

Incomplete forms will be returned to you for completion, resulting in a delay in obtaining an appointment.