KAPI'OLANI MEDICAL CENTER
for WOMEN & CHILDREN
1319 Punahou Street • Honolulu, HI 96826
Phone (808) 983-8626 • Fax (808) 983-8710

MRI REQUISITION

Now, kids can watch their favorite movie or TV show during MRI at Kapi'olani.

Appt Date _____ **Time** _____

Urgency: ☐ Routine ☐ ASAP ☐ STAT

Mode of Transportation: ☐ Wheelchair ☐ Gurney

Insurance: _____

Preauthorization #

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____

Age _____ Date of Birth _____ Sex _____ Weight _____ lbs.

If minor, Parent's / Legal Guardian's Name _____ Home Phone _____

Translator Required ☐ No ☐ Yes - Language _____ Work Phone _____

REFERRING PHYSICIAN INFORMATION

Name _____ Office Phone No. _____ Fax _____

Office Address _____ City _____ State ____ Zip _____

Copy Results To: _____

Physician Signature: _____ Date: _____

CONTRAINDICATIONS

Y	N	
☐	☐	Cerebral Aneurysm Clip
☐	☐	Cardiac Pacemaker
☐	☐	Metal in Eyes
☐	☐	Middle Ear Prosthesis

POSSIBLE CONTRAINDICATIONS

Y	N	
☐	☐	Metal Worker / Grinding
☐	☐	Pregnancy
☐	☐	Claustrophobia
☐	☐	Recent Surgery: List _____

RENAL FUNCTION - LAB VALUES

_____ _____

Bun Creatinine

Allergies: _____

TYPES OF MRI EXAMINATION REQUESTED / REASON FOR EXAM

☐ **Brain**
Region of interest
☐ cerebellum / posterior
☐ fossa
☐ brain stem
☐ supratentorial / cerebrum
☐ sella / pituitary
☐ other _____

☐ **Chest**
Region of interest
☐ aorta
☐ heart
☐ mediastinum

	LT	RT	B/L
☐ breast	☐	☐	☐

☐ other _____

☐ **Spine**
Region of interest
☐ cervical
☐ upper thoracic
☐ lower thoracic
☐ lumbar
☐ other _____

☐ **Abdomen**
Region of interest
☐ liver
☐ pancreas
☐ spleen
☐ kidneys
☐ other _____

☐ **Head & Neck**
Region of interest
☐ orbits
☐ paranasal sinuses
☐ nasopharynx
☐ neck
☐ brachial plexus
☐ other _____

☐ **Pelvis**
Region of interest
☐ uterus
☐ ovaries
☐ prostate
☐ rectum
☐ other _____

☐ **Musculoskeletal**
Region of interest

	LT	RT	B/L
☐ shoulder	☐	☐	☐
☐ humerus	☐	☐	☐
☐ elbow	☐	☐	☐
☐ forearm	☐	☐	☐
☐ wrist	☐	☐	☐
☐ hand	☐	☐	☐
☐ hip	☐	☐	☐
☐ femur	☐	☐	☐
☐ knee	☐	☐	☐
☐ tib / fib	☐	☐	☐
☐ ankle	☐	☐	☐
☐ foot	☐	☐	☐
☐ arthrogram	☐	☐	☐

☐ other: _____

☐ **MRA**
Region of interest
☐ cervical carotid / vertebral
☐ intracranial
☐ other: _____

Clinical Information:

_____

_____

_____

Radiologist Protocol

_____

Previous Surgeries / Dates _____

Previous Imaging Studies (CT, MRI, Myelo, X-Rays) / Dates _____