HAWAIʻI PACIFIC HEALTH | KAPIʻOLANI MEDICAL CENTER FOR WOMEN & CHILDREN

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MRI REQUISITION

Record Decision Support Information?

-Decision Support Vendor: ________________
-Decision Support Adherence: ________________
-Decision Support Session ID: ________________
-Decision Support Score: ________________

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: ________________

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: ________________

Okay to access CVL ☐

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 ________________

Physician Signature: ________________ Date: ____________