McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Downtime Forms

McLean Hospital Brain Imaging Center
REQUEST FOR MRI SCAN

ADT LABEL

Patient Name _____
MRN: _____ DOB: _____
Gender: ◯M ◯F Location / Unit: _____
Referring MD: _____ Ext _____

Outpatient MRI Referrals:
Patient Address _____
SSN # _____ Requesting Facility _____
Home Phone: _____ Telephone _____
Work Phone: _____ Fax (for report) _____
Insurance Information / Method of Payment _____
Preauthorization # (if required) _____

Type of Scan requested: ◯ **Brain** ◯ **C-Spine** ◯ **T-Spine** ◯ **LS-Spine** ◯ **MRA - Head** ◯ **MRA - Neck**
◯ **Other (specify views and technique desired)** _____

☐ **IV Gadolinium contrast** **Indication for contrast:** ◯ Abnormal prior scan ◯ cancer history ◯ abnormal neurological exam ◯ recommended by neurology ◯ Other indication: _____

For Gadolinium contrast studies:

History of allergic reaction to IV contrast?	Yes ◯ No ◯	History of renal disease?	Yes ◯ No ◯
History of liver disease?	Yes ◯ No ◯	Hypertension?	Yes ◯ No ◯
Diabetes?	Yes ◯ No ◯	Acute renal trauma?	Yes ◯ No ◯

GFR Factors: Race: Black / Non Black Weight: _____ Height: _____

BUN _____ Creatinine _____ Albumin _____ GFR _____

Please indicate if the patient has any of the conditions below:

☐ Weakness / paresis	☐ Malignant neoplasm of brain / spinal cord	☐ Confusion / Delirium
☐ Abnormal movements	☐ Secondary neoplasm of brain / spinal cord	☐ Hydrocephalus / edema
☐ Incoordination / Ataxia	☐ Benign neoplasm of brain / spinal cord	☐ Cranial nerve disorders
☐ Gait disorder	☐ Pituitary abnormality	☐ Myasthenia gravis
☐ Numbness	☐ Unspecified psychosis	☐ Stroke / TIA / sequellae
☐ Paresthesias	☐ Dementia or other cerebral degeneration	☐ Carotid artery disease
☐ Pain	☐ Degeneration due to ☐ Alcohol ☐ Cerebrovascular dz	☐ Vertebrobasilar artery dz
☐ Headache	☐ Developmental disorder including MR / CP	☐ Aneurysm / AVM
☐ Nausea / vomiting	☐ MS / demyelination	☐ Cerebral hemorrhage/SDH
☐ Visual disturbance	☐ Syncope	☐ Aphasia
☐ Speech / language d/o	☐ Radiculopathy	☐ Traumatic Brain Injury
☐ Incontinence	☐ Spinal Cord disease	☐ Post concussion syndrome
☐ Cognitive abnormality	☐ Memory disturbance	☐ Abnormal EEG
☐ Other (describe) _____		☐ Epilepsy / Seizures

Primary diagnosis: _____

_____

Other relevant diagnoses: _____

Indication for MRI Scan: (symptoms/findings) _____

_____

Specific diagnostic questions: _____

_____

A SIGNED / COMPLETED MRI SCREENING FORM IS REQUIRED PRIOR TO SCHEDULING MRI (FAX to 617-855-3879)

MRI Safety screening completed – no contraindications to MRI Scanning. ◯ **YES** ◯ **NO**

☐ **MRI Staff notified of possible contraindication to MRI scan (Phone Ext. 3635 Fax Ext. 3879)**

Physician's Name (printed) Physician's Signature Date