

MRI SPINE APPROPRIATENESS CHECKLIST

Patient label placed here, or minimum information below required

Patient Name: _____
 Date (YYYY-MM-DD): _____
 Date of Birth (YYYY-MM-DD): _____
 Gender: _____
 Health Card #: _____

Referring Physician Name: _____

A. Red Flags requiring Emergent Management (immediate MRI and consultation to Surgery) (consider sending patient to Emergency Department)

<input type="checkbox"/> Severe/Progressive Neurologic Deficit	<input type="checkbox"/> Cord Compression or Cauda Equina Syndrome
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B. Red Flags requiring Urgent MRI

<input type="checkbox"/> Suspected Cancer	<input type="checkbox"/> Suspected Spinal Infection	<input type="checkbox"/> Suspected Epidural Abscess or Hematoma
<input type="checkbox"/> Suspected Fracture (recommend X-ray or CT first)		

C. Mechanical Spine Pain Syndrome with no Red Flags requiring Non-Urgent MRI

(Check all that apply – there MUST be a check in sections 1, 2, and 3 below to meet imaging criteria)

1. <input type="checkbox"/> Unbearable Arm or Leg Dominant Pain (and/or)	<input type="checkbox"/> Disabling Neurogenic Claudication (and/or)	<input type="checkbox"/> Functionally Significant Neurologic Deficit
2. <input type="checkbox"/> Failure to Respond after 6 weeks of conservative care	3. <input type="checkbox"/> Considering Surgery	

D. Suspected or Known Conditions (Check all that apply)

<input type="checkbox"/> Cancer (please specify)	<input type="checkbox"/> Intradural Tumour	<input type="checkbox"/> Bone Tumour or Metastases
<input type="checkbox"/> Congenital Spine Anomaly	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Spinal Radiation
<input type="checkbox"/> Demyelination or MS	<input type="checkbox"/> Inflammatory Disease	<input type="checkbox"/> Assessment for Vertebroplasty
<input type="checkbox"/> Prior Spine Surgery (date)	<input type="checkbox"/> Arachnoiditis	<input type="checkbox"/> Post-operative Collections
<input type="checkbox"/> Follow-up for a Known Condition (please specify)		
<input type="checkbox"/> Condition Not Listed (please specify)		

Prior CT or MRI Spine Imaging (Select one)

CT MRI
 When: _____ Where: _____

Additional Clinical Information

Please provide any additional information below. Please also clearly indicate the affected area on the image to the right.

