Spinal MRI Order Form

Patient Name:	**Gender:**	**DOB:**	**Age:**
Phone #:	**Address:**		
Procedure: ☐ MRI lumbar spine ☐ MRI cervical spine ☐ MRI thoracic spine ☐ With contrast (suspected infection, cancer, post-op)			
Weight: **Kg** (may affect MRI equipment considerations)			
Comfortable in closed spaces? ☐ Yes No: ☐ Can tolerate exam, even if uncomfortable ☐ Oral meds provided ☐ Moderate sedation required			
Able to lie on back for 30 min? ☐ Yes No: ☐ Oral meds provided ☐ Moderate sedation required			

Indications *Please identify the indication(s) below — or if the indication is not listed, use the "Not Listed" box.*

- ☐ **Radiculopathy (focal neurologic deficit with progressive or disabling features):** Pain in the distribution of the nerve root (often extending below the knee), with:
  - ☐ Motor deficit, reflex deficit, and/or sensory deficit
  - ☐ Positive dural tension signs: positive straight leg raise, positive prone femoral stretch
- ☐ **Myelopathy** (Babinski or sustained clonus — cervical or thoracic MRI)
- ☐ **Suspected cauda equina syndrome**
  - ☐ New bowel or bladder dysfunction
  - ☐ Perineal numbness / saddle anesthesia
  - ☐ Persistent or increasing motor weakness
  - ☐ Significant loss of coordination in one or both legs
- ☐ **Suspected compression fracture:** osteoporosis or osteoporosis risk
- ☐ **Suspected spinal fracture:** significant recent trauma or fall
- ☐ **Suspected cancer, infection, or immunosuppression**
  - ☐ Cancer history
  - ☐ Age >70 years
  - ☐ Unexplained weight loss
  - ☐ Immunocompromised patient (Diabetes Mellitus, IV drug use, prolonged corticosteroid use)
  - ☐ Unexplained fever/chills, UTI
- ☐ **Prior surgery or planned surgery or injection**
- ☐ **Not Listed:** Other clinical Indication (specific signs and symptoms) to perform exam (please describe below). ***Note:*** *a spinal MRI will likely not be helpful if none of the indications above are present.*

Printed name of ordering provider with credentials: _____ **MD DO NP PA**

Signature of provider (no stamp): _____ **Date:** _____ **Time:** _____

Procedure Date: _____ **Scheduled Time:** _____

Facility: _____

Intermountain Healthcare

Order 50261

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