

Cook Children's Heart Center

Please complete and sign form then return or fax to Cook Children's Heart Center at (682) 885-7105.
Please send all necessary clinical records and insurance information with this form. If an urgent MRI is required, please contact Ana Builtron at (682) 885-7630.

Patient Information

Name: (L) _____ (F) _____ (M) _____

DOB (MM/DD/YY): _____ MRN: _____ Parent's Name: _____ Phone: _____

Please include a copy of the insurance card or complete name of insurance, ID, group number, subscriber's name and DOB.

Clinical information

Referring physician: _____ NPI: _____

Physician's phone: _____ Fax: _____

CC report to: _____

Relevant clinical history: _____

Surgical history: _____

Specialty: _____

Previous imaging (Check recent and applicable)

CT Cath/Angio MRI CXR Echo Nuc Med Other

Examination requested/Clinical questions: _____

Are you requesting imaging with pharmacological stress? Y N

For the patient's safety the MRI examination will not be booked unless this screening section is completed in full.

Ht: _____ Wt: _____

Y N Poorly controlled arrhythmia/frequent ectopy

Y N Cardiac Pacemaker/ICD or Pacing Leads

Y N Medical Implant (Insulin Pump, Neuro Stim, Cochlear): _____

Y N Metallic Foreign Body (Carotid or Aneurysm Clips): _____

Y N Known Hx of Metallic Fragments in the Eye: _____

If yes, Orbital X-rays Complete? Y N

Abnormal Renal Function Y N

If yes, Creatinine/clearance: _____ Test Date: _____

Y N Patient is Pregnant/Breast Feeding (LMP)

Y N History of hemoglobinopathy

Y N **Ability to lie perfectly still for a minimum of an hour and perform breath holds for 15-20 seconds**

If no, do you have a history of sedation problems? Y N

MRI Staff Use Only

Wt. _____ Ht. _____ HR: _____ BP: _____ Coil: _____ Contrast: _____ Notes: _____ Dose: _____

Notes/Concerns:

Please include all clinical notes including surgical reports, imaging reports and copies of the study for review, (if not accessible at Cook Children's).