Health Sciences North
Horizon Santé-Nord

Patient label placed here, or minimum information below required

MRI SPINE APPROPRIATENESS CHECKLIST

This checklist is required for all MRI Spine referrals (18+).
Please include with MRI requisition.

Referring Physician Name:	**Patient Name:** **Date:** **Date of Birth (YYYYMMDD):** **Gender:** **MRN/HCN:**

CHECK ANY/ALL THAT APPLY:

A. Red Flags requiring Emergent Management (immediate MRI)
(consider sending patient the Emergency Department)

☐ Severe/Progressive Neurologic Deficit	☐ Cord Compression or Cauda Equina Syndrome

B. Red Flags requiring Urgent MRI

☐ Suspected Cancer	☐ Suspected Spinal Infection	☐ Suspected Epidural Abscess or Hematoma
☐ Suspected Fracture (recommend X-Ray or CT First)		

C. Suspected or Known Conditions *(Check all that apply)*

☐ Cancer *(please specify)*	☐ Intradural Tumour	☐ Bone Tumour or Metastases
☐ Congenital Spine Anomaly	☐ Scoliosis	☐ Spinal Radiation
☐ Demyelination or MS	☐ Inflammatory Disease	☐ Post-operative Collections
☐ Prior Spine Surgery *(date)*	☐ Arachnoiditis	
☐ Follow-Up for a Known Condition *(please specify)*		
☐ Condition Not Listed *(please specify)*		

D. 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.	☐	Unbearable Arm or Leg Dominant pain	*and/or*	☐	Disabling Neurogenic Claudication /Myelopathy	*and/or* ☐ Functionally Significant Neurologic Deficit (ie foot drop)

2. ☐ Failure to Respond after 6-12 weeks conservative care	3. ☐ Considering Surgery

E. Prior CT or MRI Spine Imaging (please include previous reports if not performed at HSN)

When:	Where:

F. Alternative

Consider referring your patient for conservative treatment including active rehabilitation/physiotherapy. If treatment was not effective at 6 weeks post-onset(low back/leg pain only), refer to the Low Back - Rapid Access Clinic (ISAEC) for complete assessment and self-management plan which includes a pathway to a Neurosurgeon if appropriate.

Fax referrals to: 1-855-567-7969

Additional Clinical Information

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

Referring Physician Signature	**Date**

*This checklist is based on the **Choosing Wisely** criteria and the **CORE Back Tool**. It is required for all adult (18+) outpatient MRI spine referrals.*