ChildrensHospitalLosAngeles

International Leader in Pediatrics

Radiology/Imaging Services
Pre-Scheduling Evaluation Form

4650 Sunset Blvd., Mailstop #81, LA, CA 90027

Phone: 323-361-6111 or 6113 or 4104, Fax: 323-361-5169

Physician Referral Hotline: 1-888-MD1-CHLA, Fax: 323-361-8988

Please complete and fax to the number above or email to rvilla@chla.usc.edu or jolivares@chla.usc.edu. Thank you!

TO BE COMPLETED BY ORDERING PHYSICIAN

Ordering MD (Print name): ______________________ Pager / Phone #: ______________

Requested Exam: ____

Dx: ______________________________________ Date Needed by: ____________

Clinical Reason for Exam (r/o may not be used): ______________________________

PLEASE SUBMIT SEPARATE DOCTOR'S ORDER (PRESCRIPTION) FOR THE STUDY BEING REQUESTED

Patient's First Name: ______________________ Last Name: ______________________

Patient's Date of Birth: _____/_____/______ Patient's Telephone #: ______________________

Patient's Current Weight: __________ Patient's Alternate Telephone # or Email: ______________

Will your child be able to lie completely still for the minimum duration of:

15 minutes for CT Scan	☐ NO	☐ YES
45 minutes for MRI Scan	☐ NO	☐ YES
Does your child have Cerebral Palsy or Developmental Delay?	☐ NO	☐ YES ______________
Is your child anxious in regards to the study?	☐ NO	☐ YES ______________
Has your child ever completed this exam awake?	☐ NO	☐ YES ______________
Has your child reacted poorly to sedation?	☐ NO	☐ YES ______________

Any history or current status of any of the following: ☐ VRE ☐ MRSA ☐ RSV ☐ TB ☐ Chicken Pox ☐ Herpes

Does your child have any of the following: If yes, please specify in the space to the right:

Breathing problems while awake or asleep	☐ NO	☐ YES ______________
Current or recent infection (cold/flu/fevers)	☐ NO	☐ YES ______________
Asthma	☐ NO	☐ YES ______________
Sleep apnea/snoring	☐ NO	☐ YES ______________
Use of supplemental oxygen awake or asleep	☐ NO	☐ YES ______________
Any heart trouble, hypoplastic heart, etc.	☐ NO	☐ YES ______________

If yes, Cardiologist's name/phone #: ______________________

Date of last visit/ECHO Study ______________________

Any special breathing equipment (tracheotomy or ventilator)	☐ NO	☐ YES ______________
Significant stomach reflux (GERD)/heartburn	☐ NO	☐ YES ______________
Ventriculoperitoneal shunt or raised intracranial pressure	☐ NO	☐ YES ______________
Has your child had a CT or MRI before	☐ NO	☐ YES ______________
Has your child had either procedure with anesthesia	☐ NO	☐ YES ______________

THIS SECTION IS TO BE COMPLETED BY ANESTHESIOLOGY/NURSE PRACTITIONER for MRI/CT @ CHLA

PATIENT NEEDS: ☐ Awake ☐ Anxiolysis ☐ Deep Sedation or General Anesthesia ☐ General Anesthesia Only ☐ Cardiac Anesthesia

Completed by: ______________ Date of Review: ______________