Department of Radiology
Imaging Services

Department of Radiology/Imaging Services Pre-Scheduling Evaluation Form

4650 Sunset Blvd., MS #81, L.A. CA 90027
Phone: 323-361-2411 or 323-361-6111
Physician Referral Hotline: 1-888-MD1-CHLA, Fax: 323-361-8988

TO BE FULLY COMPLETED BY ORDERING PHYSICIAN

Date: ____________________

Ordering MD (Print name):_________________________________Pager/Phone #: ________________ Fax #:_______________

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 Current Weight:__________ kg/lb Height: __________cm/inches Alternate Tel # or email Address_______________

Determination for Need of Anesthesia: (Will patient be able to lie still for 3 to 5 minute intervals minimum duration of):

CT Scan for approx. 5 minutes to 10? ❑ No ❑ Yes

MRI minimum duration of 1 hour (able to hold 3 to 5 minute intervals)? ❑ No ❑ Yes

Does patient have any contrast allergies? ❑ No ❑ Yes

Names contrast(s)________________________Reaction______________________________

Does patient have any renal issues/failures? ❑ No ❑ Yes__________________________

For ALL MRI patients:

Does patient have VPS? ❑ No ❑ Yes ______________________

If yes, the VPS is ❑ Non programmable ❑ Programmable Type:_________ Setting: _______________

Does patient have a trach? ❑ No ❑ Yes ______________________________

Type of Trach: ❑ Shiley ❑Bivona ❑ Other___________ Size of Trach:_______mm ❑ Ped/Adult ❑ cuffed/uncuffed

Pacemaker and/or Pacemaker wires? ❑ No ❑ Yes ____

Vagal Nerve Stimulator/Deep Brain Stimulator? ❑ No ❑ Yes ______________________________________

Obesity ❑ No ❑ Yes ______________________________________

Metal [Specifically Metal Spinal Rods/ Metal Hardware/ Dental Braces-(pt for MRI Brain)] ❑ No ❑ Yes _______________

Machine/Equipment- Ventilator/ Feeding/Insulin/ Pain Pumps ❑ No ❑ Yes ______________________________________

If "yes" for ventilator, is patient ventilator dependent? ❑ No ❑ Yes ______________________________________

IF PATIENT DOES NOT REQUIRE ANESTHESIA : STOP

IF PATIENT REQUIRES ANESTHESIA PLEASE CONTINUE TO ANSWER THE FOLLOWING QUESTIONS: GO

If any questions are "Yes", please explain in the space provides as well as provide requested documentation.

Prematurity? ❑ No ❑ Yes **Length of Gestation(wks)**: _______

Patient followed by Pulmonary? ❑ No ❑ Yes ________________________________

If yes, please provide Pulmonologist name,/phone number/ date of visit : (**Attach documents of recent pulmonology**)

____

❑ CPAP ❑BiPAP ❑O2 ❑ Other:_______ ____

Sleep apnea/Airway issues/Sleep Study?(**Attach Sleep Study Results**) ❑ No ❑ Yes _______________________________

Complex Cardiac Disease/Decreased Cardiac Function ❑ No ❑ Yes ____________________________________

If yes, provide Cardiologist's name/phone number/ date of last visit/ECHO study (**Attach documents of recent cardiology note & echo**) :

____

Autism? ❑ No ❑ Yes ______________________________________

Developmental Delay? ❑ No ❑ Yes ______________________________________

Claustrophobia? ❑ No ❑ Yes ______________________________________

Intractable Seizures/Dystonia? ❑ No ❑ Yes ______________________________________

Metabolic disorder/Syndrome/Mitochondrial Disease? ❑ No ❑ Yes ______________________________________

Panhypopituitarism- ❑ No ❑ Yes ______________________________________

Stress Dose needed ❑ No ❑ Yes _________________________________

Other: ____