PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

MRI SPINE APPROPRIATENESS CHECKLIST

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.

Please include with MRI requisition.

Patient Name: _____ (Last) _____ (First)

Date of Birth: _____ (Day) _____ (Month) _____ (Year) Sex: F M

Health Card # _____ Version Code: _____

Address: _____ Postal Code: _____

Telephone # (Best Daytime): _____

Alternate #: _____

Family Physician: _____

Date	Referring MD	Signature

RED FLAGS requiring Emergent Management (immediate MRI and consultation to Surgery)

(consider sending patient to Emergency Department)

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

RED FLAGS requiring Urgent MRI

☐ Suspected Cancer ☐ Suspected Spinal Infection

☐ Suspected Epidural Abscess or Hematoma ☐ Suspected Fracture (recommend X-ray or CT first)

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 and/or ☐ Functionally Significant Neurologic Deficit

2 ☐ Failure to Respond after 6 weeks of conservative care

3 ☐ Considering Surgery

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

☐ Cancer Specify:
☐ Congenital Spine Anomaly
☐ Demyelination or MS
☐ Prior Spine Surgery, date:
☐ Intradural Tumour
☐ Scoliosis
☐ Inflammatory Disease
☐ Arachnoiditis
☐ Bone Tumour or Metastases
☐ Spinal Radiation
☐ Assessment for Vertebroplasty
☐ Post-Operative Collections
☐ Follow-up for a Known Condition Specify:
☐ Condition Not Listed Specify:

Prior CT or MRI Spine Imaging

When: Where:

Additional Clinical Information

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