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| **Patient details** | | **Referring GP details** | |
| NHS number: |  | Practice (B) Code |  |
| Name: |  | Referrer’s Name |  |
| DOB: |  | Referrer’s direct telephone number: |  |
| Address: |  | Referring Practice: |  |
| Preferred contact number: |  | Practice Tel No: |  |

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| **Reason for MRI request (please consider contacting the MRI department on 674080 if urgent)** | |
| A) Radicular back or neck symptoms causing motor symptoms –please insert power grade out of 5 |  |
| B) Suspicion of cauda equina syndrome should be referred to A+E– do not use this form |  |
| C) Suspected malignant cause of back pain. If infection is suspected, this should be referred to A+E |  |
| D) Suspected myelopathy |  |
| E) Severe radicular back or neck pain for at least 6 weeks, only if assessed by a physiotherapist and not improving |  |
| F) Assessment of suspected recent osteoporotic fracture causing severe back pain |  |
| G) Suspected spinal stenosis causing symptoms of spinal claudication AND patient would consider surgery |  |

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| **Clinical details:** | **Referral Date:** |  |
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| **Cautions and contraindications**  **Please take time to complete this as there are significant safety implications** | **YES** | **NO** |
| 1) Does the patient have a pacemaker or defibrillator? If at all possible please supply make/model |  |  |
| 2) Has the patient had heart surgery or a heart valve replacement – any metallic valves? |  |  |
| 3) Has the patient had any surgery to their Head/Eyes/Ears/Spine? |  |  |
| 4) Has the patient ever had a brain haemorrhage or aneurysm clip? |  |  |
| 5) Has the patient had any stents? |  |  |
| 6) Has the patient had an operation within the last 6 weeks? |  |  |
| 7) Has the patient ever had a penetrating eye injury involving metal? |  |  |
| 8) Has the patient got any artificial implanted devices? |  |  |
| 9) Does the patient have poorly controlled asthma? |  |  |
| 10) Is the patient pregnant? |  |  |

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| 11) Is there any known renal impairment | | | | | |  |  |
| If YES give date and value of latest eGFR: | Date: |  | Value: |  |  | | |

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| 12) Is the patient’s weight over 120kg? If so, the patient will not fit into certain scanners. | | |  |  |
| If yes, please give weight (kg): |  |  | | |

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| 13) Any known allergies? | | |  |  |
| If yes, please give details: |  |  | | |

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| 14) Interpreter required? The MRI department will need to book an interpreter in advance. | | |  |  |
| If yes, please give language: |  |  | | |

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| 15) Reduced mobility? | | | | | |  |  |
| If YES give details: | Minimal assistance |  | Unable to climb stairs |  | Wheelchair bound | |  |

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| **MRI department use only** | | | | | | | | | |
| Appointment date: |  | | | Breach Date: |  | | | | |
| MRSA screening required? | | | | | | | | **YES** | **NO** |
| If YES give date and result: | | Date: |  | | | Result: |  | | |

**Explanatory notes to referral criteria (A-G)**

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| 1. Significant radicular motor weakness (power less than 4/5), especially when associated with ongoing radicular pain, suggests ongoing compression/damage to the affected nerve root. If not treated urgently, this damage can quickly become irreversible. Acute, significant motor loss should be treated similarly to cauda equina syndrome and either referred to A+E or discussed with the neurosurgical team. |
| 1. Suspected acute cauda equina syndrome should be referred to A+E. The hallmarks of cauda equina syndrome are  * bladder dysfunction (reduced urge to urinate, poor urinary stream, eventually leading to painless urinary retention and overflow incontinence). * anal sphincter dysfunction (“constipation” or incontinence). * sexual dysfunction (erectile dysfunction, anorgasmia). * changed/reduced saddle sensation. * Bilateral leg symptoms, or a crossed SLR test (SLR on the contralateral side causes increased symptoms in the affected leg) can be indicative of impending cauda equina. |
| 1. A history of cancer, signs of infection, intravenous drug use, immunosuppression or B-symptoms (night sweats, fevers, weight loss or anorexia) should prompt consideration of a serious underlying cause for back- or radicular pain. |
| 1. Symptoms and signs of myelopathy/spinal cord compression include  * Sphincter dysfunction, similar to cauda equina * Unsteadiness, balance problems, falls * Hyperreflexia, spasticity, positive Babinsky sign * Coordination difficulties * Bilateral sensory symptoms in arms and or legs |
| 1. In most cases, radicular symptoms tend to improve over time, and after 3 months 60% improve significantly. The symptoms are often caused by radicular irritation rather than compression, for example a disc prolapse with surrounding inflammation, which resolves over time and with the help of physiotherapy. There is also evidence that after 1-2 years there is no significant difference in outcome between surgical and conservative treatment. Therefore, surgical intervention should be reserved for cases with non-remitting, severe pain after an appropriate period of conservative management. |
| 1. Osteoporotic fractures can usually be diagnosed with X-ray, but it is not possible to assess the age of the fracture. In patients with ongoing severe pain which is suspected to be due to a recent fracture, MRI can help assess the age of the fracture. Only fresh, symptomatic osteoporotic fractures can be treated with vertebroplasty. |
| 1. Lumbar spinal claudication causes typical bilateral leg symptoms, which are worse with lumbar extension such as standing and walking, and better with leaning forward (i.e. sitting or cycling) due to the decreased lumbar lordosis and increased spinal canal diameter. Surgery works better for predominant leg symptoms, not back pain. |