

# MRI SPINE APPROPRIATENESS CHECKLIST

Patient label placed here, or minimum information below required

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**.

Referring Physician Name: \_\_\_\_\_

|  |
|--|
| <b>Patient Name:</b>                   |
| <b>Date:</b>                           |
| <b>Date of Birth (YYYY □ MM □ DD):</b> |
| <b>Gender:</b>                         |
| <b>MRN:</b>                            |

**A. Red Flags requiring Emergent Management (immediate MRI and consultation to Surgery)**  
(consider sending patient to 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. 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. <input type="checkbox"/> Unrelenting or Leg Dominant Pain (and/or)             | <input type="checkbox"/> Disabling Neurogenic Claudication (and/or) | <input type="checkbox"/> Functionally Significant Neurologic Deficit |
| 2. <input type="checkbox"/> Failure to Respond after 6 weeks of conservative care | 3. <input type="checkbox"/> Considering Surgery                     |  |

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

|   |   |  |
|---|---|--|
| <input type="checkbox"/> Cancer (please specify)                          | <input type="checkbox"/> Intradural Tumour    | <input type="checkbox"/> Bone Tumour or Metastases     |
| <input type="checkbox"/> Congenital Spine Anomaly                         | <input type="checkbox"/> Scoliosis            | <input type="checkbox"/> Spinal Radiation              |
| <input type="checkbox"/> Demyelination or MS                              | <input type="checkbox"/> Inflammatory Disease | <input type="checkbox"/> Assessment for Vertebroplasty |
| <input type="checkbox"/> Prior Spine Surgery (date)                       | <input type="checkbox"/> Arachnoiditis        | <input type="checkbox"/> Post-operative Collections    |
| <input type="checkbox"/> Follow-up for a Known Condition (please specify) |   |  |
| <input type="checkbox"/> Condition Not Listed (please 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.

\_\_\_\_\_  
Referring Physician Signature

\_\_\_\_\_  
Date

