

# Child Care Grant Referral

Research Contacts:

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<b>Patient Name</b>	<b>Age/Gender:</b>	<b>Ordering Physician</b>	<b>Physician Contact info</b>
			ph:
<b>Parent or Legal Guardian</b>	<b>Phone:</b>	<b>Child's DOB</b>	fax:
	<b>work</b>		
<b>DOB</b>	<b>home</b>	<b>Child's SS#</b>	
<b>SS</b>	<b>cell</b>	<b>CCHMC MRN #</b>	
<b>Address:</b>			

**Medical History:**

**Chief Concern:**

**Circle MRI Study Desired:**

Non-contrast Brain and Spine Survey

Non-contrast Brain Survey

Non-contrast Spine Survey

<b>Prior Studies:</b>	<b>DATE</b>	<b>Report attached</b>
Brain MRI    yes    no		yes    no
Spine MRI    yes    no		yes    no
CT Brain    yes    no		yes    no
CT Spine    yes    no		yes    no

**RIBS CODE 728**

<b>Meets Eligibility Criteria</b>		
Resident of Hamilton County	yes	no
Age 6-17	yes	no
Neuro condition or disease	yes	no
Not pregnant	yes	no
Capable of lying supine 15"	yes	no
Capable of giving assent ≥ 9 yrs old	yes	no
No history of Claustrophobia	yes	no