MRI request form

RING
Radiation Imaging and Neuro-Oncology Group

Section 1: Treatment Details *(To be completed for all patients)*

Extent of surgical resection: ☐ Biopsy ☐ Subtotal ☐ Gross total
Date: _____

Radiotherapy modality: ☐ Photon ☐ Proton ☐ Carbon ion ☐ Other: _____

Fractionation schedule: ☐ Normo ☐ Hypo ☐ SRS/SFRT

Dose prescription: _____

Target volume: ☐ Focal ☐ Whole ventricle ☐ Whole brain ☐ CSI ☐ Other: _____

Last radiotherapy fraction (date): _____

Re-irradiation: ☐ Yes ☐ No
If yes: modality/date _____

Concomitant systemic therapy: ☐ Yes ☐ No
If yes: type(s) _____

Previous/current systemic treatments: ☐ Yes ☐ No
If yes: type(s) & timing _____

Clinical trial participation: ☐ Yes ☐ No
If yes: trial & timing _____

Section 2: Additional Information *(Complete if new symptoms or MRI changes)*

Symptomatic? ☐ Yes ☐ No
If yes: symptom(s) _____

Treatment for prior MRI abnormalities? ☐ Yes ☐ No
If yes: treatment type(s) & reason _____

Additional Comments / Clinical Questions:

_____

_____

Primary tumour location:
Date of initial tumour diagnosis:
Tumour histology (including WHO grade and relevant molecular markers):

Extent of surgical resection:
☐ Biopsy
☐ Subtotal resection
☐ Gross total resection
Date of resection:
_____
Radiotherapy modality:
☐ Photon therapy
☐ Proton therapy
☐ Carbon ion therapy
☐ Other: _____
Radiotherapy fractionation schedule:
☐ Normofractionation
☐ Hypofractionation
☐ SRS / SFRT
Radiotherapy dose prescription:
_____
Radiotherapy target volume:
☐ Focal
☐ Whole ventricle
☐ Whole brain
☐ Craniospinal irradiation (CSI)
☐ Other: _____
Date of last radiotherapy fraction:
Re-irradiation performed: ☐ Yes ☐ No
If yes, specify modality and date: _____

Concomitant systemic treatment during radiotherapy:
☐ Yes ☐ No
If yes, specify type(s): _____
Previous and current systemic treatments (particularly since end of radiotherapy):
☐ Yes ☐ No
If yes, specify type(s) and timing: _____
Inclusion in clinical trial:
☐ Yes ☐ No
If yes, specify trial and timing: _____

Section 2: Additional Information

(Complete if new symptoms or follow-up of prior MRI abnormalities)

Is the patient symptomatic?
☐ Yes ☐ No
If yes, specify symptom type(s): _____

Has treatment been initiated for prior MRI abnormalities?
☐ Yes ☐ No
If yes, specify treatment type(s) and clinical reason: _____