MRI request form

RING
Radiation Imaging and Neuro-Oncology Group

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

Primary tumor PA (incl molecular markers and WHO) _____

Primary tumor location: _____

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

Date: _____

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

Last radiotherapy fraction (date): _____

Fractionation schedule: ☐ Normo ☐ Hypo ☐ SRS/SFRT

Dose prescription: _____

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

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:

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