MRI Order Form

NAME: _____ AGE: _____ DOB: ____ / ____ / ____

Weight:_____ (**350lbs weight limit**)

Patient Primary Phone: _____ Patient Work Phone _____ Emergency Number:_____

Date of Appointment:_____ Additional Instructions:_____

☐ Call Report; ☐ Hold Patient & Call Report; ☐ FAX Report; #_____

☐ Delaney Read ☐ Dr. Armani Read ☐ Dr. Janik Read

☐ Perform screening x-rays for metal/foreign body clearing, or extremity x-rays if needed to correlate with MRI.

DX: (Signs/Symptoms): (ICD-10 Codes)

☐ **Serum Creatinine level – (required within 30 days with any of the following history):**

☐ Diabetes ☐ Kidney disease ☐ Hypertension ☐ Renal Dialysis ☐ History of Cancer

EXAMS REQUESTED

☐ **Without Contrast** ☐ **With/Without Contrast**

☐ **MRI Brain** ☐ **MRI Pituitary** ☐ **MRI IACs** ☐ **MRI TMJ's**

☐ **MRI Neck** ☐ **MRI C. Spine** ☐ **MRI T. Spine** ☐ **MRI L. Spine**

☐ **MRI Abdomen** ☐ **MRI Pelvis** ☐ **MRI Breast** ☐ **Left** ☐ **Right**

☐ **MRI Shoulder** ☐ **Left** ☐ **Right** ☐ **MRI Knee** ☐ **Left** ☐ **Right**

☐ **MRI Hip** ☐ **Left** ☐ **Right** ☐ **MRI Ankle** ☐ **Left** ☐ **Right**

☐ **MRI Foot** ☐ **Left** ☐ **Right**

☐ **MRA Neck** ☐ **MRA Brain** ☐ **MRA** _____

Other _____

Mark ☒ as appropriate at time of scheduling patient. Some of these conditions/devices may interfere with the study or present a hazard to patient safety.

Yes		No
☐	**Claustrophobic**	☐
☐	**Vagal NerveStimulator**	☐
☐	**Programmable Head Shunt**	☐
☐	**Cardiac (Heart) Pacemaker**	☐
☐	**Implanted Electrodes**	☐
☐	**Aneurysm Clip or Surgery**	☐
☐	**Metal Stents Placed within 6 weeks**	☐
☐	Prior Vascular Surgery	☐
☐	Prior Lumbar Spine Surgery	☐
☐	History of a foreign object striking/entering the eye that may have contained metal. FOR WHICH THE PATIENT SOUGHT MEDICAL ATTENTION. (Please perform orbit x-ray)	☐
☐	Middle Ear Prosthesis	☐
☐	Prosthetic Heart Valve	☐
☐	Known or Possible Pregnancy	☐

Have you had a previous MRI? If so where?_____

Date of last MRI?_____

If you marked any of the above items, please have the patient or guardian contact the imaging center for further consultation prior to the appointment at 815-3200.

Physician's Signature_____ _____/ _____

Date Time

THIS FORM IS PART OF THE PERMANENT MEDICAL RECORD