MRI Order Form - External

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

Weight:_____ (**350lbs weight limit on Alliance Trailer**)

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

Date of Appointment:_____ Additional Instructions:_____

☐ FAX Report; #_____ Authorization Number: _____

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

DX: (Signs/Symptoms): (ICD-9 Codes) _____

****Please Note: For Cardiac MRI's – Note required.**

☐ **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 Chest (71555)**
☐**w/contrast-70548** ☐**w/contrast-70552**
☐**w/o contrast-70547** ☐**w/o contrast-70551**
☐**w & w/o contrast-70549** ☐**w & w/o contrast-70553**

☐ **MRA Pelvis (72198)** ☐ **MRA Abdomen (74185)**

☐ **MRA Upper Extremity (73225)** ☐ **MRA Lower Extremity (73725)**

☐ **MRA Aorta & Lower Extremity Runoff (74185 & 73725 x2)**

☐ **Cardiac MRI w/o contrast, w/flow quantification (75557 & 75565)**

☐ **Cardiac MRI w & w/o contrast, w/flow quantification(75561&75565)**

Other _____

Have you had a previous MRI? If so where_____ **Date**_____

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	☐
☐	**Cardiac Only – Atrial Fibrilation or Unable to hold breath**	

If ordering MD would like to view images online, please provide email address so that we can forward access information._____

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 341-3200.

Please fax this form along with office notes, demographics and authorization with insurance information to (910) 341 – 1900.

Physician's Signature_____ _____/ _____
Date Time

Printed Name_____

THIS FORM IS PART OF THE PERMANENT MEDICAL RECORD