MRI Order Form

NAME: _____ DOB: ____/____/____ Weight*: _____ *350 lb weight limit for Cardiac MRI

Patient Primary Phone: _____ Patient Work Phone: _____

Provider Contact Phone: _____ Auth # include expire date: _____

□ Call Report □ Hold Patient & Call Report □ Fax Report: #_____
□ Delaney Read □ Dr. Janik Read

□ Perform screening X-ray for metal/foreign body clearance or extremity X-ray if needed to correlate with MRI
DX: (Signs/Symptoms): (ICD-10 Code) _____

□ **Serum Creatinine level – (required within 30 days with any of the following history if having contrast):**
□ Diabetes □ Kidney or Liver Disease □ Hypertension □ Renal Dialysis □ Age > 55

Additional Instructions: _____
Has patient had a previous MRI? If so when and where? _____

EXAMS REQUESTED

□ Without Contrast □ With/Without Contrast

□ MRI Brain □ MRI Pituitary □ MRI IACs

□ MRA Brain □ MRA Neck

□ MRI C-spine □ MRI T-spine □ MRI L-spine

□ MRI Abdomen □ MRI MRCP □ MRI Pelvis

□ MRI Breast □ Left □ Right □ MRI Chest

□ MRI Cardiac □ MRI Cardiac w/ flow & mapping

□ MRI Shoulder □ Left □ Right □ MRI Hand □ Left □ Right

□ MRI Hip □ Left □ Right □ MRI Ankle □ Left □ Right

□ MRI Foot □ Left □ Right □ MRI Knee □ Left □ Right

Other: _____

Some of these conditions/devices may interfere with the study or present a hazard to patient safety.

	Yes	No
-Ambulatory	□	□
-Any pacemaker, defibrillator, prosthetic heart valve, or stent	□	□
-Neurostimulator or Tens unit	□	□
-Surgery in the last 6 wks.	□	□
-Aneurysm clips/coils or programmable shunt		□
-Claustrophobic	□	□
-Ear or eye implants	□	□
-Known or possible pregnancy	□	□
-History of metal in the eyes (orbit x-ray needed if no prior MRI)	□	□

If any of the above items are marked **YES**, please have the patient/guardian contact the Radiology Dept. for further consultation prior to the appointment at 910-815-3200.

Physician's Signature: _____ _____ / _____
Date Time

THIS FORM IS PART OF THE PERMANENT MEDICAL RECORD