Outpatient MRI Order Form

Please complete all fields.

ECU HEALTH

Patient Name_____ DOB_____ Appt. Date/Time_____

Clinical Information/Symptoms_____

CPT Code *(if applicable)*_____ Diagnosis Code(s) _____

Decision Support/AUC information*_____

Score*_____ Vendor*_____ If not available, provide Exception Code*_____

To connect with Stanson (AUC) website: https://portal.stansonhealth.com/register/portal?code=VidantHealth

Brain-Neuro

- ☐ Brain without
- ☐ Brain with / without contrast
- ☐ Brain perfusion
- ☐ Orbits with / without contrast
- ☐ Internal auditory canal *(limited without contrast)*
- ☐ Internal auditory canal *(full with contrast)*
- ☐ Pituitary with / without contrast
- ☐ MRA extracranial (EC) / Carotid neck
- ☐ MRA intracranial (IC) / Circle-of-Willis
- ☐ MRV intracranial
- ☐ Full brain and head / Neck MRA
- ☐ Temporal bone / IAC

Spine

- ☐ Cervical without contrast
- ☐ Cervical with / without contrast
- ☐ Thoracic without contrast
- ☐ Thoracic with / without contrast
- ☐ Lumbar without contrast
- ☐ Lumbar with / without contrast
- ☐ Total spine (complete) without
- ☐ Total spine with / without contrast

Abdomen

- ☐ Abdomen and pelvis screening
- ☐ Renal mass ☐ Renal artery
- ☐ Liver ☐ Liver / Eovist
- ☐ Adrenal
- ☐ MRCP with 3D rendering

ENT-Neuro

- ☐ Soft tissue neck
- ☐ Face / sinuses
- ☐ Skull base / nasopharynx
- ☐ Trigemial neuralgia
- ☐ Parotid / salivary glands

Extremities / Ortho Imaging

Indicate side: ☐ *R* ☐ *L*

Upper extremities

- ☐ Shoulder ☐ Shoulder arthrogram
- ☐ Elbow ☐ Elbow arthrogram
- ☐ Wrist ☐ Wrist arthrogram
- ☐ Hand

Lower extremities

- ☐ Hip unilateral ☐ Hip bilateral
- ☐ Hip arthrogram
- ☐ Knee ☐ Ankle ☐ Foot
- ☐ Pelvis – bone
- ☐ Sacrum / SI joints
- ☐ Other: _____

Chest / Cardiac Imaging / Vascular

- ☐ Chest ☐ Chest wall
- ☐ Thoracic aorta
- ☐ Abdominal aorta
- ☐ Brachial plexus
- ☐ Extremity MRA
  *Specify*_____
- ☐ MR venogram
  *Specify*_____

Breast Imaging

- ☐ Breast unilateral: ☐ *R* ☐ *L*
- ☐ Breast bilateral

Pelvis

- ☐ Female pelvis
- ☐ Uterine fibroid evaluation
- ☐ Prostate
- ☐ Rectal cancer staging
- ☐ Bony pelvis *(AVN, fracture, etc.)*
- ☐ Pelvis with / without contrast evaluate for osteomyelitis/Mets
- ☐ Pelvis to evaluate fistula
- ☐ Other:_____

Comments:_____

Provider signature:_____ Provider name:_____

Supervising MD *(if applicable)*:_____

MRI Scheduling Questionnaire

ECU HEALTH

For all procedures, please complete the following:

Patient weight:_____

Authorization # *(primary insurance)*:_____ Authorization date:_____

Authorization # *(secondary insurance)*:_____ Authorization date:_____

Does the patient need sedation or anesthesia for this procedure? ☐ Yes ☐ No

For females 12-55

Is the patient post-menopausal, had a hysterectomy, tubal ligation or partner has had a vasectomy?
☐ YES ☐ NO

Is there a chance of pregnancy? ☐ YES ☐ NO
If yes, date of LMP: _____

Additional questions

Does the patient have a contrast allergy? ☐ YES ☐ NO

Does the patient have a pacemaker, defibrillator, or neuro-stimulator? ☐ YES ☐ NO

Has the patient ever had brain surgery for Aneurysm clips/coils? ☐ YES ☐ NO

Has the patient ever had metal in their eyes before? ☐ YES ☐ NO

Can this patient ambulate? ☐ YES ☐ NO

Does the patient have a port? ☐ YES ☐ NO

Please Note: additional information may need to be collected prior to scheduling