

Outpatient MRI Order Form

Please complete all fields.

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=ECUHealth>

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
- Trigeminal 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): _____

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