

Outpatient MRI Order Form



Please complete all fields.

Patient Name _____ DOB _____ Phone _____

Clinical Information/Symptoms _____

Diagnosis Code(s) _____ CPT Code _____

Brain-Neuro

- Brain without
- Brain with / without contrast
- Brain perfusion
- Rapid brain – Pediatric
- 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 contrast
- Total spine with / without contrast

Abdomen

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

ENT-Neuro

- Soft tissue neck
- Face / sinuses
- Skull base / nasopharynx
- Trigeminal neuralgia

Extremities / Ortho Imaging

Indicate side: R L

Upper extremities:

- Shoulder Shoulder arthrogram
- Elbow Elbow arthrogram
- Wrist Wrist arthrogram
- Hand Finger

Lower extremities:

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

Chest / Cardiac Imaging / Vascular

- Chest Chest wall
- Cardiac
- 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 to evaluate for osteomyelitis/Mets
- Pelvis to evaluate fistula
- Other: _____

Does the patient have an implanted device? Pacemaker/ICD Stimulator Life Vest None Other (list below)

If Other, please specify: _____

Comments: _____

Provider signature: _____ Provider name: _____

Supervising MD/DO (required for APP orders): _____

For all procedures, please complete the following:

Patient weight: _____

Primary Insurance Provider: _____ Authorization #: _____ Authorization Date: _____

Secondary Insurance Provider: _____ Authorization #: _____ Authorization Date: _____

Does the patient need sedation or anesthesia for this procedure? Neither Sedation Anesthesia

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, life vest 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

Please note: Additional information may need to be collected prior to scheduling.