

Patient name: _____ Birthdate: _____

Patient phone #: _____ Other #: _____

Date and time of exam: _____

OPEN MRI

Weight Limit: 450 lbs

- BRAIN
- PITUITARY
- INNER EAR/(IAC)
- ORBITS
- ARTHROGRAM
- NECK (SOFT TISSUE)
- CERVICAL SPINE
- THORACIC SPINE
- LUMBAR SPINE
- PELVIS/HIPS
- SI JOINTS/SACRUM
- KNEE RT/LF
- ANKLE RT/LF
- FOOT RT/LF
- SHOULDER RT/LF
- ELBOW RT/LF
- WRIST RT/LF
- HAND RT/LF
- OTHER _____

IV CONTRAST IF MEDICALLY NECESSARY

M R A

- HEAD
- NECK/CAROTIDS
- DOES PATIENT HAVE A PACEMAKER?
- IS PATIENT DIABETIC?
- SEND FILM WITH PATIENT.

REASON FOR EXAM _____

INSURANCE CARRIER FOR PATIENT _____

INSURANCE ID# _____ INSURANCE PHONE # _____

REFERRING PHYSICIAN (PRINT) _____ SIGNATURE OF PHYSICIAN _____

CONTACT NAME AT OFFICE _____ CONTACT PHONE # _____

OFFICE FAX # _____

CT SCAN

WEIGHT LIMIT: 440 LBS.

- BRAIN
- SOFT TISSUE NECK
- TEMPORAL BONES/(IAC)
- SINUSES
- LIMITED SINUSES
- CHEST
- CHEST PE PROTOCOL
- ABDOMEN
- PELVIS
- CERVICAL SPINE
- THORACIC SPINE
- LUMBAR SPINE
- ARTHROGRAM
- KNEE RT/LF
- ANKLE RT/LF
- SHOULDER RT/LF
- ELBOW RT/LF
- WRIST RT/LF
- HAND RT/LF
- FOOT RT/LF
- OTHER _____

IV CONTRAST IF MEDICALLY NECESSARY

BUN AND CREATININE LAB IF MEDICALLY INDICATED

ULTRASOUND

- OB COMPLETE <14 WKS >14 WKS
- OB LIMITED
- OB TRANSVAGINAL
- ABDOMINAL
- RENAL
- PELVIC TRANSVAGINAL IF MEDICALLY NECESSARY
- GALLBLADDER
- CAROTID
- THYROID
- SCROTAL
- VENOUS DOPPLER RT/LF
- AORTA
- OTHER _____

XRAY

- SKULL
- SINUSES
- CHEST
- HIP RT/LF
- EXTREMITY _____
- C SPINE
 - ROUTINE
 - ROUTINE WITH OBLIQUES
 - ROUTINE WITH FLEXION/EXTENSION
- LUMBAR SPINE
 - ROUTINE
 - ROUTINE WITH OBLIQUES
 - ROUTINE WITH FLEXION/EXTENSION
- THORACIC SPINE
- OTHER _____