



**PATIENT NAME:** \_\_\_\_\_ Exam Day: \_\_\_\_\_ Time: \_\_\_\_\_ : \_\_\_\_\_ am / pm  
**ICD9:** \_\_\_\_\_ **Creatinine:** \_\_\_\_\_ **Preauthorization #:** \_\_\_\_\_  
**DOB:** \_\_\_\_\_ **History:** \_\_\_\_\_ **M / F (circle one) with symptoms of:** \_\_\_\_\_  
 \_\_\_\_\_  
**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Patient Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**MAGNETIC RESONANCE IMAGING (MRI)**

<input type="checkbox"/> <b>Non Contrast</b>	<input type="checkbox"/> <b>Contrast if Indicated</b>	<input type="checkbox"/> <b>With IV Contrast</b>	<input type="checkbox"/> <b>With Intra-Articular Contrast</b>
<input type="checkbox"/> Brain	<input type="checkbox"/> Neck/Soft Tissue	<input type="checkbox"/> Femur	<input type="checkbox"/> R or <input type="checkbox"/> L
<input type="checkbox"/> IAC	<input type="checkbox"/> Shoulder <input type="checkbox"/> R or <input type="checkbox"/> L	<input type="checkbox"/> Knee	<input type="checkbox"/> R or <input type="checkbox"/> L
<input type="checkbox"/> Pituitary	<input type="checkbox"/> Humerus <input type="checkbox"/> R or <input type="checkbox"/> L	<input type="checkbox"/> Tib/Fib	<input type="checkbox"/> R or <input type="checkbox"/> L
<input type="checkbox"/> Orbits	<input type="checkbox"/> Elbow <input type="checkbox"/> R or <input type="checkbox"/> L	<input type="checkbox"/> Ankle	<input type="checkbox"/> R or <input type="checkbox"/> L
<input type="checkbox"/> Face	<input type="checkbox"/> Forearm <input type="checkbox"/> R or <input type="checkbox"/> L	<input type="checkbox"/> Foot	<input type="checkbox"/> R or <input type="checkbox"/> L
<input type="checkbox"/> TMJ	<input type="checkbox"/> Wrist <input type="checkbox"/> R or <input type="checkbox"/> L	<input type="checkbox"/> Breast	Symptoms <input type="checkbox"/> R or <input type="checkbox"/> L
<input type="checkbox"/> C-spine	<input type="checkbox"/> Hand <input type="checkbox"/> R or <input type="checkbox"/> L	<input type="checkbox"/> Heart	
<input type="checkbox"/> T-spine	<input type="checkbox"/> Abdomen Attn: _____	<input type="checkbox"/> MRA Brain/Carotids	
<input type="checkbox"/> L-spine	<input type="checkbox"/> MR Cholangiogram	<input type="checkbox"/> MRA Brain Only	
<input type="checkbox"/> Sacrum	<input type="checkbox"/> Pelvis	<input type="checkbox"/> MRA of (area of body): _____	
<input type="checkbox"/> Vertebroplasty Eval / Select level: <input type="checkbox"/> C-spine <input type="checkbox"/> T-spine <input type="checkbox"/> L-spine	<input type="checkbox"/> Hip <input type="checkbox"/> R or <input type="checkbox"/> L		
	<input type="checkbox"/> Other (specify) _____		

**APPLICABLE CONDITIONS (check all)**

<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Risk of metal in eye	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Claustrophobia	<input type="checkbox"/> Prior surgery of area	<input type="checkbox"/> Cochlear Implants
<input type="checkbox"/> Aneurysm clips	<input type="checkbox"/> Any implantable mechanical device (type): _____	

**SPECIAL INSTRUCTIONS**

I need to explain a finding on a CT of (body part): \_\_\_\_\_ done (date): \_\_\_\_\_ at WMC / Outpatient Radiology / Other (circle one)

I need to exclude acute ischemia

I need to see vessels (e.g. Aneurysm? Stenosis?)

I need to see bones (e.g. Mets Survey, Compression fx Survey)

I need to exclude inflammation/infection

I need to check for progression of a known lesion or lesions

I need to exclude ligament or cartilage injury

I need to exclude fracture

I need to tell post-surgical changes from recurrent or new pathology

Rule out: \_\_\_\_\_

**ORDERED BY:** \_\_\_\_\_  
 Print Name: \_\_\_\_\_

Report Needed:  STAT  ASAP  ROUTINE

Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

