OPEN MRI of Decatur

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PHYSICIANS ORDER

Saturday & Extended Evening Hours

ACR Accredited

Let us Pre-Cert for **YOU**!

Patient Name:_____ DOB:_____/_____/_____ Wt: _____lbs. _____ht. _____

Patient Contact #: (_____) _____ - _____ Patient Alt. #: (_____) _____ - _____ Male / Female

Referring Physician: _____ Phone #:_____

Based on the patient's history, exam and diagnosis, I have requested the below listed exam(s). I hereby certify that the exam(s) are medically necessary.

REFERRING PHYSICIAN SIGNATURE:_____NPI #:_____Date:_____/_____/_____

Appointment Date: _____ Appointment Time: _____

☐ FAX Report to: (_____) _____ - _____

HIGHFIELD OPEN MRI

			contrast
☐ **BRAIN**			☐ Y ☐ N
☐ WITH ORBITS			☐ Y ☐ N
☐ WITH IAC'S			☐ Y ☐ N
☐ WITH PITUITARY / SELLA			☐ Y ☐ N
☐ BRACHIAL PLEXUS			☐ Y ☐ N
☐ SOFT TISSUE NECK			☐ Y ☐ N
☐ CERVICAL SPINE			☐ Y ☐ N
☐ THORACIC SPINE			☐ Y ☐ N
☐ LUMBAR SPINE			☐ Y ☐ N
☐ SHOULDER	☐ L	☐ R	☐ Y ☐ N
☐ SCAPULA	☐ L	☐ R	☐ Y ☐ N
☐ HUMERUS	☐ L	☐ R	☐ Y ☐ N
☐ ELBOW	☐ L	☐ R	☐ Y ☐ N
☐ WRIST	☐ L	☐ R	☐ Y ☐ N
☐ HAND	☐ L	☐ R	☐ Y ☐ N
☐ HIP	☐ L	☐ R	☐ Y ☐ N
☐ FEMUR	☐ L	☐ R	☐ Y ☐ N
☐ LOWER LEG	☐ L	☐ R	☐ Y ☐ N
☐ KNEE	☐ L	☐ R	☐ Y ☐ N
☐ ANKLE	☐ L	☐ R	☐ Y ☐ N
☐ FOOT	☐ L	☐ R	☐ Y ☐ N
☐ PELVIS- SOFT TISSUE			☐ Y ☐ N
☐ PELVIS- BONEY			☐ Y ☐ N
☐ **ABDOMEN**			
☐ MRCP			☐ Y ☐ N
☐ LIVER			☐ Y ☐ N
☐ RENAL			☐ Y ☐ N
☐ ADRENALS			☐ Y ☐ N
☐ PANCREAS			☐ Y ☐ N
☐ Other_____			☐ Y ☐ N

☐ **MRA**

- ☐ HEAD w / wo
- ☐ NECK w / wo
- ☐ RENAL w / wo
- ☐ ADRENALS w / wo
- ☐ AORTIC ARCH w / wo
- ☐ RUNOFF w / wo
- ☐ MRV w / wo

SPECIALTY EXAMS

- ☐ PROSTATE w / wo
- ☐ UROGRAPHY w / wo
- ☐ DEFOCOGRAPHY w / wo

PATIENT HISTORY

Does the patient have a history of any of the following:

- ☐ PACEMAKER
- ☐ ANEURYSM CLIPS
- ☐ CURRENTLY PREGNANT
- ☐ SURGERY WITHIN THE LAST 6 WEEKS
- ☐ IMPLANTED DEVICES
- ☐ CLAUSTROPHOBIA

DIAGNOSIS CODE

_____ _____

_____ _____

_____ _____

SPECIAL INSTRUCTIONS

CD ☐ Film ☐ Amicas/Intelirad ☐

With Patient or Courier or FedEx (please circle one)