

[www.openmriofdecatur.com](http://www.openmriofdecatur.com)

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

- |   |   |                 |   |
|---|---|-----------------|---|
| <input type="checkbox"/> BRAIN                  |   | <b>contrast</b> | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> WITH ORBITS            |   |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> WITH IAC'S             |   |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> WITH PITUITARY / SELLA |   |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> BRACHIAL PLEXUS        |   |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> SOFT TISSUE NECK       |   |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> CERVICAL SPINE         |   |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> THORACIC SPINE         |   |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> LUMBAR SPINE           |   |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> SHOULDER               | <input type="checkbox"/> L <input type="checkbox"/> R |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> SCAPULA                | <input type="checkbox"/> L <input type="checkbox"/> R |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> HUMERUS                | <input type="checkbox"/> L <input type="checkbox"/> R |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> ELBOW                  | <input type="checkbox"/> L <input type="checkbox"/> R |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> WRIST                  | <input type="checkbox"/> L <input type="checkbox"/> R |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> HAND                   | <input type="checkbox"/> L <input type="checkbox"/> R |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> HIP                    | <input type="checkbox"/> L <input type="checkbox"/> R |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> FEMUR                  | <input type="checkbox"/> L <input type="checkbox"/> R |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> LOWER LEG              | <input type="checkbox"/> L <input type="checkbox"/> R |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> KNEE                   | <input type="checkbox"/> L <input type="checkbox"/> R |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> ANKLE                  | <input type="checkbox"/> L <input type="checkbox"/> R |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> FOOT                   | <input type="checkbox"/> L <input type="checkbox"/> R |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> PELVIS- SOFT TISSUE    |   |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> PELVIS- BONEY          |   |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> ABDOMEN                |   |                 |   |
| <input type="checkbox"/> MRCP                   |   |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> LIVER                  |   |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> RENAL                  |   |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> ADRENALS               |   |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> PANCREAS               |   |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> Other _____            |   |                 | <input type="checkbox"/> Y <input type="checkbox"/> N |

### MRA

- |   |  |
|---|--|
| <input type="checkbox"/> HEAD w / wo        | <input type="checkbox"/> NECK w / wo     |
| <input type="checkbox"/> RENAL w / wo       | <input type="checkbox"/> ADRENALS w / wo |
| <input type="checkbox"/> AORTIC ARCH w / wo | <input type="checkbox"/> RUNOFF w / wo   |
| <input type="checkbox"/> 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)