CareFIRST IMAGING

PORT ORANGE
4690 Clyde Morris Blvd.
Port Orange, Florida 32129
OFFICE: 386-262-1930
SCHEDULING: 833-682-7818
FAX: 888-978-5541

PATIENT NAME: ______________________ **DATE:** ______________

PHONE: ______________________ **D.O.B.** ______________

❑ **DIAGNOSIS/ICD 10:** ______________ ❑ **AUTH:** ______________

IF CONTRASTED: BUN: ________ **CREATININE:** ________ **EGFR:** ________ **DATE LABS WERE PERFORMED:** ________

Physician Notes / Other Procedures: ______________________

Based upon this patient's diagnosis, I have requested the below procedure(s).I hereby feel the tests are medically necessary.

PHYSICIAN: ______________________ **PHYSICIAN SIGNATURE:** ______________

OFFICE PHONE: ______________ **OFFICE FAX:** ______________ **AFTER HOURS:** ______________

MRI

IV Contrast: ____w/o ____ w/ + w/o

- ❑ Cervical (spine)
  - ❑ Alar Protocol (whiplash injury protocol)
  - ❑ Flex/ExT
- ❑ Thoracic (spine)
- ❑ Lumbar (spine)
- ❑ Brain ❑ Trauma SWI/DTI
  - ❑ 3D Volumetric Analysis
- ❑ IACs/Brain Protocol
- ❑ PITUARY/Brain Protocol
- ❑ Orbits
- ❑ Face
- ❑ Neck
- ❑ Hip ❑ R ❑ L
- ❑ Knee ❑ R ❑ L
- ❑ Ankle ❑ R ❑ L
- ❑ Foot ❑ R ❑ L
- ❑ Shoulder ❑ R ❑ L
- ❑ Elbow ❑ R ❑ L
- ❑ Wrist ❑ R ❑ L
- ❑ Hand ❑ Finger ❑ R ❑ L
- ❑ Other: ______________
- ❑ **3D Reconstruction/Modeling:** *PT education, treatment, planning, compliance, initiation/ CPT 76376, only if+ study.*
  Available for the Spine, Knee, and Shoulder.

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MRA

IV Contrast: ____w/o ____ w/ + w/o

- ❑ Circle of Willis
- ❑ Carotid (neck) (❑ w/o ❑ w/ + w/o)
- ❑ Thoracic Aorta (chest)
- ❑ Abdomen (w/ + w/o IV Contrast)
- ❑ Renal Arteries
- ❑ Pelvis / Iliac
- ❑ MRV Head/Brain
- ❑ Neck
- ❑ Other: ______________
- ❑ **3D Reconstruction/Modeling:** *PT education, treatment, planning, compliance, initiation/ CPT 76376, only if+ study.*
  Available for the Spine, Knee, and Shoulder.

XRAY

- ❑ Chest (2 views)
- ❑ Spine
- ❑ Neck ❑ Cervical ❑ Thoracic ❑ Lumbar
  - ❑ C-Spine Flex/Ext ❑ L-Spine Flex/Ext
  - ❑ Flex/Ext
- ❑ Davis Series
- ❑ Other: ______________

MRI INSTRUCTIONS

1. Notify your Doctor if you have any of the following:
   - PACEMAKER/ICD
   - SURGERY IN THE PAST 6 WEEKS
   - HISTORY OF METAL WORK / WELDING

   If Yes: may need Orbit XRAYS
2. Wear loose fitting clothes without any metal
3. Your exam can take 15 minutes to 1 hour to complete.

SCAN FOR GPS DIRECTIONS TO THE FACILITY

PORT ORANGE OFFICE
386-262-1930

SCHEDULING
833-682-7818

FAX
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TRAUMATIC BRAIN INJURY (TBI) ORDER FORM

☐ STAT

PATIENT NAME:______________________ DATE:______________

PHONE:______________________ D.O.B.______________

DATE OF INJURY:______________________

☐ MRI BRAIN (DTI/SWI) CONTRAST Y ☐ N ☐

INSURANCE/ATTORNEY:______________________ CLAIM #:______________

Physician Notes / Other Procedures:______________________

Based upon this patient's diagnosis, I have requested the below procedure(s).I hereby feel the tests are medically necessary.

PHYSICIAN:______________________ PHYSICIAN SIGNATURE:______________

OFFICE PHONE:______________ OFFICE FAX:______________ AFTER HOURS:______________

CLINICAL INDICATIONS

(Must Be Completed)

- ❏ Loss of consciousness at time of injury (Perdidia del conocimiento en el momento de la lesion)
- ❏ Altered consciousness/Disorientation at the time of injury (Conocimiento alterado/desorientacion en el momento de la lesion)
- ❏ Post-Traumatic amnesia (less than 24-hours) (Amnesia postraumatica (en menos de 24 horas)

COGNITIVE SYMPTOMS

- ❏ Attention difficulties (Dificultades de atencion)
- ❏ Concentration problems (Problemas de concentracion)
- ❏ Orientation problems (Problemas de orientacion)
- ❏ Memory problems (Problemas de memoria)

PHYSICAL SYMPTOMS

- ❏ Headaches (Dolores de cabeza)
- ❏ Fatigue (Fatiga)
- ❏ Blurred Vision (Vision borrosa)
- ❏ Insomnia (Insomnio)
- ❏ Uneven gait (Problema alcaminar)
- ❏ Seizures (Convulsiones)
- ❏ Dizziness (Mareo)
- ❏ Nausea (Nauseas)

BEHAVIORAL CHANGES

- ❏ Irritability (Irritabilidad)
- ❏ Sleep disturbances (Perdida del sueno)
- ❏ Depression (Depresion)
- ❏ Anxiety (Ansiedad)
- ❏ Loss of initiative (Perdida de iniciativa)
- ❏ Problems related to employment, marriage relationships, home management or school management (Problemas en el trabjo, con el matrimonio, en la casa, or en la escuela)
- ❏ Problems with emotional control (Problemas al controlar las emociones)

Other Symptoms/Notes (Otros Sintomas/Notas):______________________

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If you checked Yes for one or more, you may have a Traumatic Brain Injury that would be demonstrable on DTI/SWI.