

STAT

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
- PITUITARY/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
- Abdomen
- Pelvis Bony
- Other: _____

3D Reconstruction/Modeling: PT education, treatment, planning, compliance, initiation/CPT 76376, only if + study.
Available for the Spine, Knee, and Shoulder.

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
- Other: _____

XRAY

- Chest (2 views)
- Spine 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.

