CareFIRST IMAGING

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❑ **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
❑ 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
❑ 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.*

ACR AMERICAN COLLEGE OF RADIOLOGY ACCREDITED FACILITY

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.