

3T MRI ORDER FORM



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Billings, MT 59101
Phone: 406-237-5525
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Patient Information

Today's Date: ___/___/___ Appointment Date: ___/___/___ Appointment Time: _____ Arrival Time: _____

Patient Name: _____ Date of Birth: ___/___/___

Gender: Male Female Phone: (_____) _____

Follow up appointment: Not Scheduled Date: ___/___/___ Time: _____

Previous imaging studies? Yes No Where? Big Sky Other: _____

Safety Pre-Screening: Does the patient have any of the following: *Pacemaker, Neurostimulator, Implanted device, Aneurysm Clips, Artificial Heart Valves, Heart Stent, Allergy to Gadolinium?*
 Yes No *If yes, please indicate.*

Referring Physician

Name: _____ Phone: _____

Clinic: _____ Fax: _____

Signature: _____

Reports and Delivery

- ASAP
- Phone Report # _____
- Fax Report # _____
- Report & Images on CD
- Send CD with Patient
- Send copy to: _____

3T MRI

Head

- Brain
- IAC
- Orbits
- Pituitary

Angiography/Venography

- Brain (Circle of Willis MRA)
- Brain (Venography)
- Neck (Carotid MRA)
- Chest MRA
- Renal MRA
- Aorta with Run-off MRA
- _____

Contrast

- Without
- With and Without



Contrast Screening:

- Is the patient diabetic or does the patient have renal disease?*
- Yes No
- Is the patient over 70?*
- Yes No
(If yes to any, current renal function labs needed.)

Spine

- Cervical Spine
- Thoracic Spine
- Lumbar Spine
- GravityScan

Orthopedic

- | | | |
|-----------------------------------|--------------------------------|-------------------------------|
| <input type="checkbox"/> Shoulder | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Elbow | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Wrist | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Hand | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Hip | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Knee | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Ankle | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Foot | <input type="checkbox"/> Right | <input type="checkbox"/> Left |

Breast

- Breast - Bilateral

Reason for MRI

Diagnosis Code(s): _____

Body

- Soft Tissue Neck
- Abdomen
- MRCP
- Pelvis
- Rectum

Other Exam

Special Instructions

Physician Referral Order Form