3T MRI ORDER FORM

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Yellowstone Medical Center
Billings, MT 59101
Phone: 406-237-5525
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Physician Referral Order Form

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

Spine
☐ Cervical Spine
☐ Thoracic Spine
☐ Lumbar Spine
☐ **Gravity**Scan

Breast
☐ Breast

Body
☐ Soft Tissue Neck
☐ Abdomen
☐ MRCP
☐ Pelvis
☐ Rectum

Angiography/Venography
☐ Brain (Circle of Willis MRA)
☐ Brain (Venography)
☐ Carotid MRA
☐ Chest MRA
☐ Renal MRA
☐ Aorta with Run-off MRA
☐ ____________________

Orthopedic

☐ Shoulder	☐ Right	☐ Left
☐ Elbow	☐ Right	☐ Left
☐ Wrist	☐ Right	☐ Left
☐ Hand	☐ Right	☐ Left
☐ Hip	☐ Right	☐ Left
☐ Knee	☐ Right	☐ Left
☐ Ankle	☐ Right	☐ Left
☐ Foot	☐ Right	☐ Left

Other Exam
☐ ____________________

Contrast
☐ Without
☐ With and Without

Arthrogram
Orthopedic
☐ Yes ☐ No

Reason for MRI
Diagnosis Code(s):
____
____
____
____
____

Special Instructions
____
____
____

Visit us online at www.bigskydiagnosticimaging.com