Mid West Imaging
MRI of Springfield

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Outpatient Imaging MRI CT Ultrasound EMG/NCV XRAY

Patient Name: _____Patient DOB: _____

Patient Phone: _____

Date of Exam: _____ Time of Exam: _____ Or, please call patient to schedule

TYPE OF STUDY(IES) REQUESTED: (Please circle) MRI CT Other

| | | | |
|---|---|---|---|
| _____ Brain | _____ Shoulder | _____ L | _____ R |
| _____ Pituitary / IAC | _____ Elbow | _____ L | _____ R |
| _____ Chest | _____ Wrist | _____ L | _____ R |
| _____ Cervical Spine | _____ Hip | _____ L | _____ R |
| _____ Thoracic Spine | _____ Knee | _____ L | _____ R |
| _____ Lumbar Plexus | _____ Foot | _____ L | _____ R |
| _____ Lumbar Spine | _____ Ankle | _____ L | _____ R |
| _____ Soft Tissue Neck | _____ Humerus | Distal | Proximal |
| _____ Abdomen | _____ Leg | Upper | Lower |
| _____ Pelvis / Sacrum | | | |
| _____ Brachial Plexus | | | |

_____ MRA _____ _____ Arthrogram _____

_____ EMG/NVC _____ _____ XRAY _____

Ultrasound _____

_____ MRI / CT Study to be performed without contrast
_____ CT Study to be performed with contrast ORAL IV
_____ MRI / CT Study to be performed with & without contrast

Diagnosis/Reason for Exam_____

Ordering Physician: _____

Address: _____

Phone: _____ Fax: _____