



1420 E. Bradford Parkway Springfield, Missouri 65804 Phone (417) 885-1100 Fax (417) 885-1109

Outpatient Imaging (Circle one Please): MRI Open MRI CT Ultrasound X-Ray

Patient Name: Patient DOB:

Patient Height: Patient Weight LBS Is the patient Claustrophobic? Y or N

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
XRAY

Ultrasound

- MRI / CT Study to be performed without contrast
CT Study to be performed with contrast ORAL and/or IV
MRI / CT Study to be performed with & without contrast

\*\*If patient is over the age of 60 and needs contrast, please send labs (CMP or BMP-Creatinine\GFR) with in the last 30 Days. \*\*

Diagnosis Code: CPT Code:

Ordering Physician: Provider Signature

Provider NPI# \*PLEASE ATTACH COPIES OF INSURANCE CARDS TO ORDERS\*

Address:

Phone: Fax:

Insurance: Auth. Number Valid Through Date:

NOTICE OF CONFIDENTIALITY

The document(s) accompanying this facsimile transmission contains Protected Health Information belonging to the sender which is legally and medically privileged. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient you are hereby notified that any disclosure, copying, distribution, or taking of any action on the contents of this facsimile information is strictly prohibited. If you have received this facsimile transmission in error, please immediately notify us by telephone to arrange for return of the document(s) to us. Rev. 09/16/2020