Mid West Imaging
MRI of Springfield

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:_____