

MRI of Springfield Order Form

MRI	CT	Ultrasound	X-Ray
Patient Name: _____		Patient DOB: _____	
Patient Phone: _____		Patient Height: _____	Patient Weight _____ LBS
Parent Name _____		Parent Phone _____	Is the patient Claustrophobic? Y or N

TYPE OF STUDY REQUESTED (Circle One)

MRI	MRA	CT	CTA
<input type="checkbox"/> Brain <input type="checkbox"/> Orbits <input type="checkbox"/> Pituitary <input type="checkbox"/> IACs <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Brachial Plexus <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Lumbar Plexus <input type="checkbox"/> Sacrum <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Liver <input type="checkbox"/> Pancreas <input type="checkbox"/> Kidney <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Shoulder <input type="checkbox"/> Scapula <input type="checkbox"/> Humerus <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Pelvis <input type="checkbox"/> Hip <input type="checkbox"/> Femur/Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Tibia/Fibula <input type="checkbox"/> Ankle <input type="checkbox"/> Foot	<input type="checkbox"/> Head <input type="checkbox"/> Sinus <input type="checkbox"/> Orbits <input type="checkbox"/> Temporal Bones <input type="checkbox"/> Maxillofacial <input type="checkbox"/> Facial Bones <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Chest <input type="checkbox"/> Chest(Hi Res) <input type="checkbox"/> Chest(Low Dose) <input type="checkbox"/> Abdomen <input type="checkbox"/> Tri-Phase Liver <input type="checkbox"/> Pelvis <input type="checkbox"/> Urogram <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Chest/Abdomen/Pelvis <input type="checkbox"/> Abdomen/Pelvis <input type="checkbox"/> Abdomen/Pelvis(Stone Protocol)

Contrast (Circle One)	Contrast (Circle One)
Without With & Without contrast Arthrogram	Without With Arthrogram With & Without contrast ORAL and/or IV

XRAY _____

Ultrasound _____

****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 & AUTHORIZATIONS*****

Phone: _____ Fax: _____

Insurance: _____ Auth. Number _____ Valid Through Date: _____

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