

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:

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

Contrast (Circle One)

Without _____ With & Without Contrast
 Arthrogram

Contrast (Circle One)

Without _____ With _____ Arthrogram
 With & Without Contrast _____ ORAL and/or IV

XRAY _____

Ultrasound _____

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

Diagnosis (ICD10) Code: _____ CPT Code: _____

Ordering Physician: _____ Provider Signature _____

Provider NPI# _____ *****PLEASE ATTACH COPIES OF INSURANCE CARDS & AUTHORIZATIONS*****

Provider Phone: _____ Fax: _____

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

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