Mid West Imaging
MRI of Springfield

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Springfield, Missouri 65804
Phone (417) 885-1100
Fax (417) 885-1109

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

____ Brain
____ Orbits
____ Pituitary
____ IACs
____ Cervical Spine
____ Brachial Plexus
____ Thoracic Spine
____ Lumbar Spine
____ Lumbar Plexus
____ Sacrum
____ Soft Tissue Neck
____ Liver
____ Pancreas
____ Kidney

____ Left ____ Right

MRA

____ Shoulder
____ Scapula
____ Humerus
____ Elbow
____ Forearm
____ Wrist
____ Hand
____ Pelvis
____ Hip
____ Femur/Thigh
____ Knee
____ Tibia/Fibula
____ Ankle (Ankle/Midfoot)
____ Foot(Midfoot/Toe)

CT

____ Head
____ Sinus
____ Orbits
____ Temporal Bones
____ Maxillofacial
____ Facial Bones
____ Soft Tissue Neck
____ Chest
____ Chest(Hi Res)
____ Chest(Low Dose)
____ Calcium Scoring
____ Abdomen
____ Tri-Phase Liver
____ Tri-Phase Kidney
____ Pelvis

____ Left ____ Right

____ Shoulder
____ Elbow
____ Wrist
____ Hand
____ Hip
____ Knee
____ Ankle
____ Foot
____ Cervical Spine
____ Thoracic Spine
____ Lumbar Spine
____ Chest/Abdomen/Pelvis
____ Abdomen/Pelvis
____ Abdomen/Pelvis(Stone Protocol)
____ Urogram

CTA

____ Head
____ Head/Neck
____ Neck
____ Chest(PE Protocol)
____ Chest(Aorta)
____ Abdomen
____Abdomen/Pelvis
____ Bilateral Runoff

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:_____