



3T IMAGING

OF MORTON GROVE

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PATIENT'S NAME: _____ AGE: _____

PATIENT'S #: _____

PHYSICIAN: _____

CLINICAL HISTORY/INDICATION: _____

cc/NAME: _____ FAX NUMBER: _____

PHYSICIAN'S SIGNATURE: _____

RQI # / Pre-Certification #: _____

Date: _____

ICD-9: _____

PERTINENT CLINICAL DIAGNOSIS REQUIRED. (DO NOT USE "RULE OUT", "POSSIBLE", "SUSPECTED" OR "FOLLOW-UP" DIAGNOSIS. USE SPECIFIED CODE #'S, SIGNS, SYMPTOMS, PATIENT COMPLAINTS, KNOWN DIAGNOSIS.)

MRI SCREENING		CT CONTRAST SCREENING	
<input type="checkbox"/> PACEMAKER	<input type="checkbox"/> HISTORY OF WORKING WITH METAL	<input type="checkbox"/> DIABETES	<input type="checkbox"/> IODINE / CT CONTRAST ALLERGY (Please call our office)
<input type="checkbox"/> PREGNANT	<input type="checkbox"/> OCULAR TRAUMA	<input type="checkbox"/> RENAL DISEASE	<input type="checkbox"/> PREGNANT
<input type="checkbox"/> CEREBRAL ANEURYSM CLIPS	<input type="checkbox"/> OTHER NON-ORTHOPEDIC METAL IMPLANTS	<input type="checkbox"/> AGE OVER 65	<input type="checkbox"/> GLUCOPHAGE/GLUCOVANCE
<input type="checkbox"/> METALLIC FOREIGN BODY IN EYE			<input type="checkbox"/> BUN/CRE Testing @ 3T
<input type="checkbox"/> IV SEDATION		IF ANY OF THE ABOVE ARE CHECKED, BUN/ CREATININE WITHIN 30 DAYS IS REQUIRED. BUN _____ Cr _____ DATE ____/____/____	
<input type="checkbox"/> INTRAVENOUS CONTRAST PER RADIOLOGIST DISCRETION (If you do not select this option, please select a contrast option where applicable.)			

X	MAGNETIC RESONANCE (MR)	X	CT SCAN (Multidetector)	X	X-RAY	X	ULTRASOUND
	wo w/wo BRAIN		wo w/wo w BRAIN		ORBITS for MRI		ABDOMEN COMPLETE
	w/wo IAC'S		wo SINUSES		CHEST PA & LATERAL		LIVER / GB / PANCREAS (RUQ)
	w/wo BRAIN & IAC'S		wo FACIAL BONES		ABDOMEN complete		KIDNEY / BLADDER
	w/wo ORBITS		w/wo w NECK SOFT TISSUE		ABDOMEN KUB (1 view)		THYROID
	w/wo PITUITARY		wo w CHEST		3 5 F/E CERVICAL SPINE		SCROTAL / TESTICULAR
	B BREAST		w PE CHEST		THORACIC SPINE		PELVIC TRANSABD & TRANSVAG
	wo w/wo CERVICAL SPINE		wo w/wo w ABDOMEN / PELVIS		3 5 F/E LUMBAR SPINE		OBSTETRICAL -1st TRIMESTER
	wo w/wo THORACIC SPINE		wo Renal Stone Study		PELVIS		OBSTETRICAL - 2nd / 3rd TRIMESTER
	wo w/wo LUMBAR SPINE		w/wo CT Urogram		R L B HIP		BIOPHYSICAL PROFILE
	w/wo *BRACHIAL PLEXUS		CERVICAL SPINE		R L B KNEE		*CAROTID DOPPLER
	wo *Intracranial MRA		THORACIC SPINE		R L B FOOT		AORTA
	wo w/wo *Carotid / Neck MRA		LUMBAR SPINE		R L B ANKLE		R L B LE ARTERIAL DOPPLER
	w *Thoracic Aorta MRA		R L B SHOULDER		R L B SHOULDER		R L B UE LE VENOUS DOPPLER
	w Abdominal Aorta / Renal MRA		R L B ELBOW		R L B HAND		UE LE MUSCULOSKELETAL STUDY
	w *UE/LE Peripheral MRA		R L B WRIST		R L B WRIST		NOTE: UE = Upper Extremity LE = Lower Extermity w = with contrast wo = without contrast w/wo = with and without contrast * = requires icd-9 code R = right L = left B = bilateral (ie both sides) 3 = 3 views 5 = 5 views F/E = Flexion/Extension
	wo w/wo *NECK SOFT TISSUE		R L B HIP		R L B FINGER		
	wo w/wo *CHEST		R L B KNEE		R L B RIBS		
	wo w/wo ABDOMEN		R L B ANKLE		R L B CLAVICLE		
	MRCP		R L B FOOT		R L B HUMERUS		
	wo w/wo PELVIS		3D RECONSTRUCTION		R L B ELBOW		
	MYELOGRAM		CT Calcium Score		R L B FOREARM		
	ARTHROGRAM		CT ANGIOGRAPHY (CTA)		R L B FEMUR		
	R L B SHOULDER		*CAROTID / NECK CTA		R L B TIB - FIB		
	R L B ELBOW		*THORACIC AORTA CTA		R L TOES		
	R L B WRIST		*ABDOMINAL AORTA CTA		OTHER:		
	R L B HIP / OSSEOUS PELVIS		R L B UE LE *PERIPHERAL CTA				
	R L B KNEE		BONE DENSITOMETRY				
	R L B ANKLE		OTHER:				
	R L B FOOT						
COMMENTS: _____							

PRIORITY READING - Physician must provide a contact name and number. Otherwise, STAT reading will not be provided.