

PHYSICIAN'S INFORMATION - *To be completed by Dr.'s office & signed by ordering physician, or attach Dr.'s signed prescription.*

Today's Date: _____ Type of MRI/MRA: _____
Specify area(s) to be scanned

Diagnosis (MUST include clinical history):

CPT: _____ ICD-9: _____

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Patient Weight: _____ Height: _____ Age: _____

IF PATIENT REQUIRES SEDATION, what type: (Chart notes required.)

- General sedation (with Anesthesiologist)
 IV sedation Patient taking own meds.
 Sedated patients require driver.

► **ORDERING PHYSICIAN SIGNATURE:** _____ PCP: _____

PRINT Physician's name: _____

Physician office contact person: _____

PH #: (____) _____ FAX #: (____) _____

CC report to: _____

IF HAVING CONTRAST - DOES PATIENT HAVE:

- Kidney problems/Renal disease** Yes No
Hepatic disease/past or pending liver transplant Yes No
Rx for Hypertension Yes No
Rx for Diabetes Yes No | **Age >60** Yes No

If Yes to any, require lab information within last 45 days:

BUN _____ Cr _____ GFR _____ Date: _____

Location: _____

OK to provide i-Stat lab test at OAI if needed Yes No

PATIENT HISTORY

Possibility of pregnancy? Yes No

Previous surgeries - same area? Yes No

Type: _____

History of cancer? Yes No Type/Where: _____

Previous films? Plain CT MRI Other Where/When: _____

Metal implants (pacemakers, shunts, etc.) or injuries (pins, etc.)? Yes No If yes, explain: _____

Porta Cath Yes No Is patient claustrophobic? Yes No Unknown

REMINDERS Minor w/parent Sedated patient, needs driver Patient needs assistance Wheelchair/lifting

REQUESTS

- Please call patient
 FAX or Phone appt. time to office

SCHEDULE

- ASAP
 Patient's convenience

RESULTS

- ASAP - Same day
 24 - 48 Hours

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (M.I.) _____ DOB: ____/____/____ M F

SS#: _____ - _____ - _____ Home Ph#: _____ Work/Cell #: _____ City: _____

DOI: ____/____/____ Work Auto (State _____) Other **Claim #:** _____

INSURANCE INFORMATION

Primary insurance: _____ Subscriber: Self Other: _____

Policy #: _____ Group #: _____ **Authorization necessary?** Yes No

AUTHORIZATION #s: _____ } Due to pre-auth requirements by most insurance companies
 Auth. valid from _____ to _____ please provide CPT and ICD-9 #s above.

Other insurance: _____ Subscriber: Self Other: _____

Policy #: _____ Group #: _____ **Authorization necessary?** Yes No

AUTHORIZATION #s: _____ Auth. valid from _____ to _____

APPOINTMENT INFORMATION - *To be completed by ordering physician staff.*

Follow-up Appointment with Doctor: _____

DATE: ____/____/____ TIME: _____ AM PM (Initials: _____ Date: _____)