

MRI

APPOINTMENT INFORMATION Appointment Date: _____ Check-in Time: _____ Appointment Time: _____

Check Appropriate Site Below — See Map On Back

Squalicum Parkway
2930 Squalicum Parkway
Suite 101

Northwest Avenue Open MRI
4029 Northwest Avenue
Suite 102

1 PATIENT INFORMATION (please print) See Important Exam Information On Back

Name: _____

DOB: _____

Daytime Telephone: _____

Referring M.D.: _____

CC: _____

Primary Insurance Name: _____

Comparison Films: Patient Bring Office Will Send None

Pregnant: Yes No

Weight: _____

2 WARNING - MRI is NOT allowed for patients with:

- Pacemakers or Cardioverters

CAUTION - Patients with any of the following MUST be cleared by a radiologist before an MRI can be performed:

To avoid rescheduling please provide documentation (ex: operative report, implant card information).

- Heart, ear, or brain surgery?
- Implanted device (aneurysm clips, stents, valve, pacemaker)
- Metal fragments in the eyes?
- Post-operative on the area of interest?
- Medication patch (fentanyl, nicotine etc)? -must be removed for MRI

Allow extra time for appointment if any of the following are marked:

- Claustrophobic? (Schedule Open MRI when possible and provide oral sedation as needed)
- Issue preventing patient from holding still such as severe pain, altered cognition, mental state, etc.?
- Physical limitations? (ex: Wheelchair)

3 EXAM TYPE - Please mark one or more of the following:

<p>Brain</p> <p><input type="checkbox"/> Routine Brain</p> <p><input type="checkbox"/> To include MRA – Circle of Willis</p> <p><input type="checkbox"/> To include MRA – Neck</p> <p><input type="checkbox"/> MS Brain</p> <p><input type="checkbox"/> IAC for tumor</p> <p><input type="checkbox"/> Maxillofacial</p> <p><input type="checkbox"/> Orbits</p> <p><input type="checkbox"/> Pituitary</p> <hr/> <p>Neck/Chest</p> <p><input type="checkbox"/> Soft Tissue Neck</p> <p><input type="checkbox"/> Brachial Plexus</p> <p><input type="checkbox"/> Chest</p> <p><input type="checkbox"/> Breast</p>	<p>Spine</p> <p><input type="checkbox"/> C-Spine</p> <p><input type="checkbox"/> T-Spine</p> <p><input type="checkbox"/> L-Spine – Routine</p> <p><input type="checkbox"/> L-Spine – Post Op (< 3yrs)</p> <p><input type="checkbox"/> Spine Screen – Compression fx</p> <p><input type="checkbox"/> Spine Screen – Mets/Tumor</p> <p><input type="checkbox"/> MS Spine</p> <hr/> <p>Pelvis</p> <p><input type="checkbox"/> Pelvis</p> <p><input type="checkbox"/> S.I. Joints</p> <p><input type="checkbox"/> Female Pelvis/GYN</p> <p><input type="checkbox"/> Male Pelvis/Prostate</p> <p><input type="checkbox"/> Fistula</p> <p><input type="checkbox"/> Rectal Cancer</p>	<p>MR angiography/MRA</p> <p><input type="checkbox"/> MRA-Specify Body Part</p> <p>(To include MRI of assoc. area)</p> <hr/> <p>Abdomen</p> <p><input type="checkbox"/> Liver</p> <p><input type="checkbox"/> Kidneys</p> <p><input type="checkbox"/> Pancreas</p> <p><input type="checkbox"/> MRCP (gallbladder and bile ducts)</p> <p><input type="checkbox"/> Adrenal Glands</p> <p><input type="checkbox"/> Enterography</p> <p><input type="checkbox"/> Abdomen Other – Specify</p> <hr/> <p><input type="checkbox"/> Bone Marrow Screening -Multiple Myeloma</p>	<p>Extremity - Specify Body Part</p> <p>(<input type="checkbox"/> Left <input type="checkbox"/> Right)</p> <p><input type="checkbox"/> Hip <input type="checkbox"/> Shoulder</p> <p><input type="checkbox"/> Knee <input type="checkbox"/> Elbow</p> <p><input type="checkbox"/> Ankle <input type="checkbox"/> Wrist</p> <p><input type="checkbox"/> Mid-Foot <input type="checkbox"/> Hand</p> <hr/> <p><input type="checkbox"/> Arthrogram</p> <p><input type="checkbox"/> Infection/Tumor</p> <p><input type="checkbox"/> Non-Routine - Specify:</p> <hr/> <p><input type="checkbox"/> Other - Specify:</p> <hr/>
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3a GADOLINIUM INSTRUCTIONS

- Contrast use per radiologist exam protocol instructions unless stated otherwise

Special instructions: _____

- Providers are welcome to call a radiologist at 733-0430 for additional exam ordering information

4 Symptoms/Clinical Indications/History (Disease, Injury, Pain, Pathology, Signs and/or Symptoms; **No "Rule Out"):** _____

Additional Information/What do you want the radiologist to look for (optional)? _____

X _____
Provider Signature Required

Stat Report Desired (choose one)

- Fax Report (Fax number required) _____
- Call Report (Provider cell phone number required) _____

EXAM PREPARATION:

- Exams of the **abdomen and pelvis** require patient to be without food/drink 4 hours prior to exam. Take regular medications as prescribed.
- Patients will generally be asked to remove clothing, jewelry, watches, and shoes for the exam. A gown or scrubs will be provided.

EXAM INFORMATION:

- Claustrophobia: patients with mild to moderate claustrophobia may be able to tolerate the exam with 5-10 MG Valium PO 30 minutes prior to the exam. Sedated patients **MUST HAVE A DRIVER to take them home.** Ordering provider must prescribe and direct patient to self-sedate.
- MRI exams ordered with IV contrast (gadolinium) are indicated for questions of tumor, vascular abnormality, inflammatory process, and in lumbar spines post-op less than 3 years. *(continued>>)*

- Exams ordered with intra-articular injection of contrast (arthrograms) involve an injection into the joint under fluoroscopy. Shoulder arthrograms are preferred for patients younger than 50 years of age.

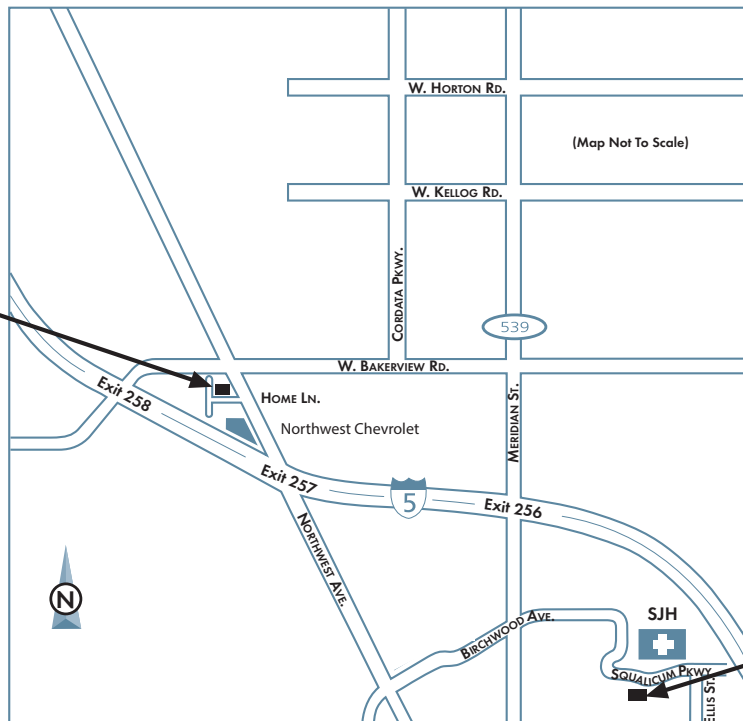
- Patients with an **accessed** port may receive their contrast through their port.

- For the majority of MRI exams, patients will be allowed to select a genre of music to listen to during the exam.

Please allow one hour for each MRI exam ordered.

LOCATION MAP

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 4029 Northwest Avenue, Suite 102



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 2930 Squalicum Parkway, Suite 101

