

Physician Written MRI Order Form

To Schedule MRI Studies: Phone 1-800-258-4674

Fax this form to 1-800-253-7569

***Required Information**

*Patient Name: _____ *Date of Birth: _____ *SSN: _____

*Home Phone: _____ *Work Phone: _____

*Physician's Signature: _____ Phone: _____
(must provide signature)

Physician's Name (please print): _____

Billing Information Health MVA IW/C Other Authorization # _____

Insurance Company: _____ Policy#: _____

This order includes authorization to perform/obtain an orbital x-ray exam, if necessary, based on patient history.

Requested MRI / MRA Procedure

(please check off desired scan type)

High Field

High Field Open

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Brain | <input type="checkbox"/> Hip | <input type="checkbox"/> Lt. <input type="checkbox"/> Rt. | <input type="checkbox"/> Brain & Neck Angio |
| <input type="checkbox"/> Cervical | <input type="checkbox"/> Knee | <input type="checkbox"/> Lt. <input type="checkbox"/> Rt. | <input type="checkbox"/> Brain MRA |
| <input type="checkbox"/> Thoracic (Spine) | <input type="checkbox"/> Ankle | <input type="checkbox"/> Lt. <input type="checkbox"/> Rt. | <input type="checkbox"/> Neck MRA (carotid bifurcation) |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Foot (fore foot) | <input type="checkbox"/> Lt. <input type="checkbox"/> Rt. | <input type="checkbox"/> Chest MRA (arch & great vessels) |
| <input type="checkbox"/> Lumbar | <input type="checkbox"/> Wrist | <input type="checkbox"/> Lt. <input type="checkbox"/> Rt. | <input type="checkbox"/> Abdomen MRA |
| <input type="checkbox"/> Pelvis | <input type="checkbox"/> Elbow | <input type="checkbox"/> Lt. <input type="checkbox"/> Rt. | <input type="checkbox"/> Pelvis MRA |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Lt. <input type="checkbox"/> Rt. | <input type="checkbox"/> Lower Leg MRA <input type="checkbox"/> Lt. <input type="checkbox"/> Rt. |
| <input type="checkbox"/> Breast | <input type="checkbox"/> Thigh | <input type="checkbox"/> Lt. <input type="checkbox"/> Rt. | |
| <input type="checkbox"/> MRCP | <input type="checkbox"/> MR Arthrogram | | |
| <input type="checkbox"/> Prostate | <input type="checkbox"/> Other Scan Type _____ | | |

*** Gadolinium scans require Creatinine Level on patients 70+ years, women 60+ years, diabetic and all renal patients**

Required for Renal Screening, Including GFR if known.

Creatinine _____ Lab Date _____ GFR _____ Lab Date _____

ICD9 Codes: _____

Diagnosis/Symptoms _____

Appointment date/time: _____

Gadolinium Requested
 Anesthesia
 Interpreter Required
 Language _____

*** MRI scan cannot be scheduled without the required information**

Location (Select one):

- ___ First available appointment at any UMass Memorial MRI location in Worcester
- ___ UMass Memorial MRI - CMMIC Biotech Park, 367 Plantation Street, WorcesterTax ID# 04-2981362
- ___ UMass Memorial MRI - Shrewsbury Street, 214 Shrewsbury Street, WorcesterTax ID# 04-3454298
- ___ UMass Memorial MRI - CMMIC University Campus, 55 Lake Avenue North, WorcesterTax ID# 04-2981362
- ___ UMass Memorial MRI - Memorial Campus, 119 Belmont Street, Worcester.....Tax ID# 04-3454298
- ___ UMass Memorial MRI - Marlborough Campus, 157 Union Street, MarlboroughTax ID# 20-2293995
- ___ UMass Memorial MRI - Wing Memorial Hospital, 40 Wright Street, PalmerTax ID# 04-3454298
- ___ UMass Memorial MRI - HealthAlliance Leominster, 100 Hospital Road, LeominsterTax ID# 04-3561571
- ___ UMass Memorial MRI - HealthAlliance Fitchburg, 275 Nichols Road, FitchburgTax ID# 04-3561571
- ___ UMass Memorial MRI - Clinton Hospital, 201 Highland Street, Clinton.....Tax ID# 041-185-520