Shields HEALTH CARE GROUP
OFFICIAL MRI PROVIDER

PHYSICIAN ORDER FORM – MRI Services
To schedule exams, call: 1-800-258-4674
Or fax this form to: 1-800-253-7569

Please include clinical notes with this order

APPT. DATE & TIME	*REQUEST*
	☐ *Routine*
	☐ *STAT*

☐ **Boston/Granite Ave.** 04-3046812
☐ **Boston/Western Ave.** 04-3001031
☐ **Brockton** 04-2935687
☐ **Chelmsford** 45-2979715
☐ **Dartmouth** 04-3043884
☐ **Dedham** 04-3046812
☐ **Falmouth** 04-2220716
☐ **Framingham** 20-2043301
☐ **Greenfield** 16-1766731
☐ **Harwich** 04-2103600
☐ **Hyannis (CC Hosp.)** 04-2103600
☐ **Hyannis (Wilken's Ctr.)** 04-2103600
☐ **Leominster** 04-3561571
☐ **Lowell (Main Campus)** 45-2979715
☐ **Lowell (Saints Campus)** 45-2979715
☐ **Marlborough** 20-2293995
☐ **New Bedford** 04-3043884
☐ **Palmer** 04-3454298
☐ **Portsmouth, NH** 02-0501695
☐ **Sandwich** 04-2220716
☐ **Springfield** 04-3454301
☐ **Ware** 04-3454301
☐ **Wellesley** 04-2461479
☐ **West Yarmouth** 04-3494613
☐ **Weymouth** 04-3046796
☐ **Woburn** 46-2523117
☐ **Worcester (Shrews.St.)** 04-3454298
☐ **Worcester (Memorial)** 04-3454298
☐ **Worcester (University)** 04-3454298

PATIENT INFORMATION

Patient Name: _____ **DOB:** _____ **SSN:** _____

Weight: _____ **Phone:** _____ **Cell:** _____

☐ **Private Health** ☐ **Auto** ☐ **W/C** ☐ **Other:** _____ **Insurance Co:** _____

Subscriber ID: _____ **Employer of Policy Holder:** _____

Authorization: _____ **Valid Dates:** _____ **Translation Services Needed?** ***YES*** ***NO***

INJURY & PAIN INFORMATION

Diagnosis (ICD-10 codes): _____

Date of Injury: _____ **Location of Pain:** _____ **Severity of Pain (circle):** ***SEVERE*** ***MODERATE*** ***MILD***

Mechanism of Injury: _____

History: _____

REFERRING PHYSICIAN INFORMATION

Physician Name: _____ **Phone:** _____ **Address:** _____

Office Location (if different): _____ **Physician Signature:** _____

MRI SCAN INFORMATION

TECHNOLOGY: ☐ **1.5T High-field** ☐ **1.5T High-field Open** ☐ **3T High-field** ***(Lowell –Saints' Campus)*** ☐ **3T High-field Open** ***(Hyannis/Wilken's; Woburn; Springfield)***

☐ **With and Without Contrast**
NOTE: Contrast scans require Creatinine & BUN Level on all patients· (60+ years and/or who have diabetes, hypertension liver or renal disease)

Lab Values
Lab Date: _____
Creatinine: _____
GFR: _____
BUN: _____

NEUROLOGY
☐**Brain** ☐**MRA Brain** ☐**Brachial Plexus** ☐**Pituitary** ☐**MRA Neck (carotid bifurcation)** ☐**Orbits** ☐**MRV Brain**
☐**Temporal Bones/IAC** ☐**Neck/Face** ☐**Neuroquant** ☐**Other**_____

SPINE
☐**Lumbar** ☐**Cervical** ☐**Thoracic** ☐**Sacrum** ☐**Other**_____

BODY
☐**Chest/Thorax** ☐**Pelvis** ☐**Abdomen** ☐**MRCP (biliary)** ☐**Other**_____

BREAST
☐**Diagnostic** ☐**Implant Evaluation** ☐**MRCAD** ☐**Other**_____

MUSCULOSKELETAL
☐**LEFT** ☐**RIGHT**
☐**Shoulder** ☐**Ankle** ☐**Elbow** ☐**Foot** ☐**Wrist** ☐**Thigh** ☐**Hip** ☐**Knee** ☐**Arthrogram** ☐**Other**_____

VASCULAR IMAGING
☐**Chest Aorta** ☐**Abdominal Aorta** ☐**Runoff, Lower Ext.** ☐**Renal Arteries** ☐**MRV:** _____ ☐**Other:** _____

PELVIC
☐**Prostate** ☐**Other:** _____

Prostate
☐ **Prostate C-/C+**
☐ **Reformat for 3D Quantification**
☐ **Other:** _____

PSA Values
**** Provide 3 most recent PSA values****
Date: _____ ***Value:*** _____
Date: _____ ***Value:*** _____
Date: _____ ***Value:*** _____