# Radiology Order Form

Pt. Name: ____________________ Med. Rec. # ____________

DOB: __________________ Phone #: ______ - ______ - ______

Address: ______________________________________________

City State Zip

Medical/Insurance: ______________________________________

**James W. Aston Radiology, University Hospital - Zale Lipshy Radiology, University Hospital - St. Paul Radiology, Southwestern Center for Breast Care, Mary Nell and Ralph B. Rogers MRI Center, Algur H. Meadows MRI Center, PET, Outpatient Building, St. Paul Professional Office Building Radiology**

**Radiology Centralized Scheduling**
Rogers MRI, Zale Lipshy,
St. Paul, Aston, OPB, POB
**(214) 645-XRAY (9729) / Fax: (214) 645-9289**

Center for Breast Care - Scheduling: (214) 645-4673 / Fax: (214) 645-2506
Meadows MRI - Scheduling: (214) 590-4525 / Fax: (214) 590-4529
PET Facility - Scheduling: (214) 267-1513 / Fax: (214) 267-1523

Today's Date: ____________________

*Physicians should order ONLY procedures that are medically necessary for the diagnosis or treatment of the patient. The patient may have to assume financial responsibility for exams performed without acceptable indications.*

**Modality:** ☐ X-Ray/Fluoro ☐ DEXA Bone Density ☐ U/S ☐ CT ☐ Nuc Med ☐ Special Proc ☐ PET
☐ MRI **(additional questionnaire on back must be completed)**

**Examination/Procedure Requested:**

Procedure may be modified in the interest of radiological appropriateness: ☐ Yes ☐ No

**ICD-9 Code (must support procedure requested):**

**Brief Clinical History Which Must Include Signs, Symptoms, Chief Complaint and Questions To Be Answered By This Examination**

*(For Follow-up Exam, Must List **New** Indications To Document Medical Necessity - Federal Requirement.)*

*(Illegible or incomplete information will delay tests considerably.)*

| Name of Ordering Practitioner | Beeper No. | **Attending Physician (Required)** | Authorized Signature |
|---|---|---|---|

***(Must be signed by an MD, PA or NP. Requests without all of the above information cannot be processed.)***

Food/Drug Allergy ☐ Yes ☐ No

IV Contrast Allergy ☐ Yes ☐ No

Creatinine Level:

Date Drawn:

Patient Weight greater than 300 lbs? ☐ Yes ☐ No

Diabetic ☐ Yes ☐ No

Ambulatory ☐ Yes ☐ No ☐ Inpatient ☐ Outpatient

Pregnant? ☐ Yes ☐ No ☐ N/A

If Pregnant, how many weeks? ________

Date of onset of last menstrual period: _____/_____/_____
*(Required for all female patients between ages 12 to 50 years)*

Name of person scheduling exam: ______________________ Phone #: (_____) ______________

Physician Contact Number for Urgent Findings: (_____) ____________________

**Schedule As:** ☐ Urgent (within 24 hours) ☐ Today (First Available)
☐ Next Available Time (within 72 hours)

Preferred date: _____/_____/_____ Preferred time: _______AM / PM

Patient's Phone Numbers: Home: (_____) ________________ Work: (_____) ________________

(Outpatients cannot be scheduled without a valid telephone number.)



FORM # 7210-007 (02/07)

Health Information Management Department Copy

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Pt. Name:______________________ Med. Rec. # ____________

DOB: ____________________ Phone #: ______ - ______ - ______

Address: ________________________________________________

________________________________________________
City State Zip

Medical/Insurance: ________________________________________

## Past Medical History (Must be Completed if MRI Requested)

| | Question | Yes | No |
|---|---|---|---|
| 1. | Do you have or have you ever had a Pacemaker? | ☐ Yes | ☐ No |
| 2. | Do you have Brain Aneurysm Clips? | ☐ Yes | ☐ No |
| 3. | Have you had Brain Surgery? | ☐ Yes | ☐ No |
| 4. | Have you ever performed Metal Work? | ☐ Yes | ☐ No |
| 5. | Are you Claustrophobic? | ☐ Yes | ☐ No |
| 6. | Do you have a Neuro Stimulator? | ☐ Yes | ☐ No |
| 7. | Do you have Eye or Ear (Cochlear) Implants? | ☐ Yes | ☐ No |
| 8. | Do you have metal implants? Clips? Bullets? | ☐ Yes | ☐ No |
| 9. | Have you ever had a reaction to MRI contrast? Dye? | ☐ Yes | ☐ No |
| 10. | Do you have tattooes or body piercings? | ☐ Yes | ☐ No |
| 11. | Do you have Flo-Lan Pump (Cardiac MR)? | ☐ Yes | ☐ No |
| 12. | How much do you weigh? __________ pounds | | |

* If **Yes** is answered to any of the questions above, please provide additional information:

________________________________________________

________________________________________________

## Past Medical History (Must be Completed for all MRI Studies)

### Study Requested

| | | |
|---|---|---|
| ☐ Brain | ☐ Cervical Spine | ☐ Joints |
| ☐ Posterior Fossa/IAC | ☐ Thoracic Spine | ☐ Knee |
| ☐ Skull Base/Nasopharynx | ☐ Lumbar Spine | ☐ Ankle |
| ☐ Pituitary Fossa | ☐ Screen Spine | ☐ Hip |
| ☐ Soft Tissue Neck | ☐ Brachial Plexus | ☐ Shoulder |
| ☐ Seizure Protocol | ☐ Pelvis | ☐ Wrist |
| ☐ MRA/Circle of Willis | ☐ Chest | ☐ Elbow |
| ☐ MRA/Vertebrobasilar | ☐ Abdomen | ☐ Body/MRA/MRV (describe below) |
| ☐ MRA/Carotid Bifucations/Neck | ☐ Upper Extremities | ☐ Other (describe below) |
| ☐ MRI Venogram/Sinuses | ☐ Lower Extremities | |

Contrast? ☐ Yes ☐ No ☐ Radiologist to decide

**Radiologist's Comments:**

________________________________________________

________________________________________________

________________________________________________

________________________________________________