# OUTPATIENT RADIOLOGY
# MRI ORDERS

12401 Washington Blvd.
Whittier, CA 90602

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ACT: MR:

DOB:
ADM: RM:

**Location** ☐ **Whittier** ☐ **Downey**

Patient Name _____ DOB _____ Age _____

Patient Contact Number # _____

Reason for Exam _____
(Indications, Symptoms, Relevant Clinical History)

☐ eMD Record Available ☐ Recent Progress Notes Attached

ALLERGIES ☐ Contrast ☐ No Known Allergies ☐ Other _____

**CONTRAST Must select one of the following** ☐ **Requesting Radiology Consult – Need order clarification**

☐ With **OR** Without Intravenous Contrast per Radiology Protocol
☐ With Intravenous Contrast
☐ No Intravenous Contrast
☐ With **AND** Without Intravenous Contrast

*Please Order Serum Creatinine prior to any contrast exam for patients who are over 60 years of age, have a history of, or are diagnosed with diabetes, renal insufficiency, hypertension, and severe hepatic disease or liver transplant (post or pending).*

**MRI**

☐ MRI Head ☐ MRI Pituitary ☐ MRI CSF Flow ☐ MRI Spectroscopy
☐ MRI Skull Base ☐ MRI TMJ ☐ MRI Internal Auditory Canal (IAC)
☐ MRI Orbit ☐ MRI Sinus ☐ MRI Face
☐ MRI Neck ☐ MRI Chest ☐ MRI Abdomen ☐ MRI Pelvis ☐ MRCP

**MRI Spine - REQUIRES AUTHORIZATION**

☐ MRI Cervical Spine ☐ MRI Thoracic Spine ☐ MRI Lumbar Spine

**MRI EXTREMITY** ☐ **Right** ☐ **Left** ☐ **Bilateral**

☐ MRI Shoulder ☐ MRI Humerus ☐ MRI Elbow ☐ MRI Forearm ☐ MRI Wrist
☐ MRI Hand ☐ MRI Upper Extremity No Joint ☐ MRI Hip ☐ MRI Thigh
☐ MRI Knee ☐ MRI Calf ☐ MRI Ankle ☐ MRI Forefoot ☐ MRI Heel
☐ MRI Lower Extremity No Joint ☐ Include Arthrogram

**MRA**

☐ MRA Head ☐ MRA Neck ☐ MRA Chest ☐ MRA Abdomen ☐ MRA Pelvis
☐ MRA Upper Extremity ☐ Right ☐ Left ☐ Bilateral
☐ MRA Lower Extremity ☐ Right ☐ Left ☐ Bilateral
☐ MRA Run-Off (includes abdomen, pelvis and lower extremity)

**MRV**

☐ MRV Head ☐ MRV Abdomen/Pelvis ☐ MRV Abdomen *Only* ☐ MRV Pelvis *Only*
☐ MRV Upper Extremity ☐ Right ☐ Left ☐ Bilateral ☐ MRV Lower Extremity ☐ Right ☐ Left ☐ Bilateral
☐ Other (please specify) _____

**LABORATORY**

☐ Ordered ☐ Resulted and Faxed to Scheduling

**EXAM COMPLETION PRIORITY**

☐ Routine (completed as schedule allows)
☐ Urgent (completed within 2 days)
☐ STAT (exam completed today)

**STAT Exams**
☐ Call Clinician/Office with results and hold patient until direction is given
☐ Fax results and send patient back to office

_____ _____ _____ _____
Time Date Physician Signature Physician Name (Please Print)

Alternate Office Contact Name _____ Number _____

*Radiology Scheduling Direct Phone Number 562.906.5572* *Radiology Scheduling Fax 562.464.5018*