DIA - Craddick Medical Office Building, 400 Rosalind Redfern Grover Parkway Suite 110 (Located next to MMH)

DIA - Legend’s Park Office Building, 5615 Deauville Blvd, Suite 110 (Located near Scarborough Sports Complex)

Abell-Hanger Medical Pavilion, 200 Andrews Highway (Directly South of Midland Memorial)

**Appointment Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Time:** \_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_ ICD-10-CM Codes: \_\_\_\_\_\_\_\_\_\_\_\_ Appropriate Use Score (MRI): \_\_\_\_\_\_

Clinical Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preauthorization #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BODY WITH&WITHOUT CONTRAST** □ Abdomen

□ Brachial Plexus

□ Soft Tissue Neck

□ Thorax

□ Urogram

□ Female Pelvis

□ Male Pelvis/Prostate

**LOWER EXTREMITY MUSCULOSKELETAL**

**(Select Contrast Preference)**

□ Without Contrast

□ With and Without Contrast

□ \_\_\_\_Bony Pelvis\* Right Left

□ \_\_\_\_SI Joints\* Right Left

□ \_\_\_\_Hip\* Right Left

□ \_\_\_\_Femur\* Right Left

□ \_\_\_\_Knee\* Right Left

□ \_\_\_\_Tib/Fib\* Right Left

□ \_\_\_\_Ankle\* Right Left

□ \_\_\_\_Foot\* Right Left

□ \_\_\_\_Toe(s)\* Right Left

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*X-rays are required.

**SPINE (Select Contrast Preference)**

□ Without Contrast

□ With Contrast

□ Cervical\*

□ Thoracic\*

□ Lumbar\*

□ Sacrum/Coccyx\*

\* X-rays are required.

**BODY WITHOUT CONTRAST**

□ MR Cholangiogram

□ Soft Tissue Pelvis

□ Other \_\_\_\_\_\_\_\_\_\_\_

**SEDATION WITH ANESTHESIA**

- Provider to fax H & P with order

for MRI Exam

**-** Patient must call (432) 221-4082

to schedule anesthesia assessment

prior to day of appointment.

- Arrangements for sedation must be

made prior to scheduled appt. time.

**BREAST WITH&WITHOUT CONTRAST**

□ Breast Bilateral

**LABS** □ Draw Creatinine **GFR:** \_\_\_\_\_\_

**OUTSIDE LAB RESULTS:**

Creatinine: \_\_\_\_\_\_ Date Drawn: \_\_\_\_\_\_\_

**(Creatinine Range 0.6 – 1.3 mg/dL)**

Location Drawn: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CARDIAC WITH&WITHOUT CONRAST**

□ With and Without Contrast

**HEAD (Select Contrast Preference)**

□ Without Contrast

□ With and Without Contrast

□ Routine Brain

□ With and Without Contrast for Alzheimer’s

□ Pituitary

□ Temporomandibular Joints (TMJ’s)

□ Internal Auditory Canals (IAC’s)

□ Facial Nerve

□ Orbits

**MRA WITH&WITHOUT CONTRAST**

□ MRA/MRV Head

**MRA WITHOUT CONTRAST** □ MRA Head Circle of Willis

**UPPER EXTREMITY MUSCULOSKELETAL**

**(Select Contrast Preference)**

□ Without Contrast

□ With and Without Contrast

□ \_\_\_\_Shoulder\* Right Left

□ \_\_\_\_Humerus\* Right Left

□ \_\_\_\_Forearm\* Right Left

□ \_\_\_\_Wrist\* Right Left

□ \_\_\_\_Hand\* Right Left

□ \_\_\_\_Finger(s)\* Right Left

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*X-rays are required

**MRA WITH CONTRAST**

MRA WITH CONTRAST

□ Abdomen Aorta

□ Bilateral Leg Angiogram

□ MRA Neck – Neurovascular

(includes Arch, Subclavians,

Carotids, Vertebrals)

□ Renal Arteries

□ Peripheral Run-Off

□ Thoracic Aorta

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Provider Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_**

(This order includes authorization to perform/obtain an orbital x-ray, **PRN**)

**PATIENT MEDICATIONS:** Please bring a list of all over the counter & prescription medications being taken; to include the dose & frequency.

**MRI PATIENT PREPS**

**MRA/MRI Abdomen, MRCP & MRA Lower Extremities:** No food or water for eight (8) hours prior to the MRI exam (NPO 8 hours).

**MRI Pelvis for rectal tumor and/or staging:** 24 hours prior to the MRI exam, consume clear liquids only.

**MRI Pelvis Male/Female (Prostate):** Two days prior to exam: Eat a light, low residue meal at noon. After this meal clear liquids only. Day prior to exam: Continue clear liquids and start drinking one glass (8oz minimum) Water every two hours until midnight: The more water the better At 4pm, drink one bottle of Magnesium Citrate At 10pm, take three (3) Dulcolax (Bisacodyl) tablets with one (8oz) glass of water. Day of exam: **Continue drinking only water but nothing to eat.**  Two (2) hours before your exam, administer a fleet enema. Medication may be taken with small sips of water.

**MRI SAFETY SCREENING**

Please answer the questions below. For your safety, you will be asked these questions several times prior to entering the MRI Room. If there is a possibility of metal in your eyes, an x-ray may be necessary prior to the MRI. If you answer “yes” to any of the questions with a \*, list the manufacturer, model #, and serial #.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **DO YOU HAVE:** | **YES** | **NO** | **If Yes to questions with a \*, please provide device manufacturer, model #, and serial #.** | **DO YOU HAVE:** | **YES** | **NO** |
| \*Cardiac Pacemaker/Defibrillator | \_\_\_\_ | \_\_\_\_ |  | Joint Replacement, Bone Plates/Screws/Rods | \_\_\_\_ | \_\_\_\_ |
| \*Breast Tissue Expanders | \_\_\_\_ | \_\_\_\_ |  | Cardiac Stent(s) | \_\_\_\_ | \_\_\_\_ |
| \*Cerebral Aneurysm Clip(s) or Coil(s) | \_\_\_\_ | \_\_\_\_ |  | Dentures/Retainers/Braces/Partials | \_\_\_\_ | \_\_\_\_ |
| \*Cerebral Shunt | \_\_\_\_ | \_\_\_\_ |  | Metal Removed from the Eyes, if YES by whom? | \_\_\_\_ | \_\_\_\_ |
| \*Ear/Cochlear Implant(s) | \_\_\_\_ | \_\_\_\_ |  | Hearing Aids | \_\_\_\_ | \_\_\_\_ |
| \*Electronic Implant(s): Insulin pump, pain pump, neuro-stimulator. | \_\_\_\_ | \_\_\_\_\_ |  | Possibility of Pregnancy | \_\_\_\_ | \_\_\_\_ |
| \*Heart Valve(s) | \_\_\_\_ | \_\_\_\_ |  | Radiation/Chemotherapy | \_\_\_\_ | \_\_\_\_ |
| \*IUD or Other Birth Control Device | \_\_\_\_ | \_\_\_\_ |  | Renal Insufficiency, Kidney failure, End Stage Renal Disease or Dialysis? | \_\_\_\_ | \_\_\_\_ |
| \*Other Stent, Filter, Coil(s) | \_\_\_\_ | \_\_\_\_ |  | Surgical Clip(s) | \_\_\_\_\_ | \_\_\_\_ |
| \*Prosthesis (Orbital, Limb, Penile) | \_\_\_\_ | \_\_\_\_ |  | Tattoo(s) or Tattooed Makeup | \_\_\_\_\_ | \_\_\_\_ |
| \*Vascular Aneurysm Clip(s) or Coil(s) | \_\_\_\_ | \_\_\_\_ |  | Transdermal(medication) Patch | \_\_\_\_ | \_\_\_\_ |
| Abandoned Leads from Cardiac or Other Device(s). | \_\_\_\_ | \_\_\_\_ |  | Retained BB, Bullet or Shrapnel in Body. | \_\_\_\_ | \_\_\_\_ |
|  |  |  |  |  |  |  |
| Are you Claustrophobic? NOTE: If medication is desired for anxiety, it MUST be provided by your medical provider. | \_\_\_\_ | \_\_\_\_ | If yes, please rate your claustrophobia on a scale of 1-10 with 10 being extremely claustrophobic. 1 2 3 4 5 6 7 8 9 10 | | | |
| Have you ever experienced a problem related to an MRI Procedure? | \_\_\_\_ | \_\_\_\_ | If yes, what occurred? | | | |
| Do you have other devices and/or foreign body objects that are not listed above? | \_\_\_\_ | \_\_\_\_ | If yes, what? | | | |