2009 WARRENVILLE ROAD
LISLE, IL 60532

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PATIENT'S NAME:______________________

PATIENT'S PHONE#:______________________ DOB:______________________

PHYSICIAN:______________________

CLINICAL HISTORY/INDICATION:______________________

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RQI #/Pre-certification:______________________

Date:______________________

ICD-10:______________________

cc/NAME:______________________ FAX NUMBER:______________________

PHYSICIAN'S SIGNATURE:______________________

PERTINENT CLINICAL DIAGNOSIS REQUIRED, (DO NOT USE"RULE OUT","POSSIBLE", "SUSPECTED" OR "FOLLOW-UP" DIAGNOSIS USE SPECIFIC CODE #'S, SIGNS, SYMPTOMS, PATIENT COMPLAINTS, KNOWN DIAGNOSIS.)

MRI SCREENING

- ☐ PACEMAKER
- ☐ PREGNANT
- ☐ CEREBRAL ANEURYSM CLIPS
- ☐ METALLIC FOREIGN BODY IN EYE
- ☐ HISTORY OF WORKING WITH METAL
- ☐ OCULAR TRAUMA
- ☐ OTHER NON-ORTHOPEDIC METAL IMPLANTS

CT CONTRAST SCREENING

- ☐ DIABETES
- ☐ RENAL DISEASE
- ☐ AGE OVER 60
- ☐ IODINE/CT CONTRAST ALLERGY (PLEASE CALL OUR OFFICE)
- ☐ PREGNANT
- ☐ GLUCOPHAGE/GLUCOVANCE
- ☐ BUN/CRE TESTING

IF ANY OF THE ABOVE ARE CHECKED, BUN/ CREATININE WITHIN 30 DAYS REQUIRED. BUN______Cr______DATE___/___/_____

☐ INTRAVENOUS CONTRAST PER RADIOLOGIST (IF YOU DO NOT SELECT THIS OPTION, PLEASE SELECT A CONTRAST OPTION WHERE APPLICABLE.)

☐	MRI
	wo w/wo BRAIN
	w/wo IAC'S
	w/wo BRAIN & IAC'S
	w/wo PITUITARY
	w/wo ORBITS
	B BREAST
	wo w/wo CERVICAL SPINE
	wo w/wo THORACIC SPINE
	wo w/wo LUMBAR SPINE
	R L w/wo BRACHIAL PLEXUS
	wo Intracranial MRA
	wo w/wo Carotid/Neck MRA
	w/wo Thoracic Aorta MRA
	w/wo Abdominal Aorta/Renal MRA
	w/wo UE/LE PERIPHERAL MRA
	wo w/wo NECK SOFT TISSUE
	wo w/wo CHEST
	wo w/wo ABDOMEN
	wo w/wo MRCP
	wo w/wo PELVIS
	R L B SHOULDER
	R L B ELBOW
	R L B WRIST
	R L B HIP OSSEOUS & PELVIS
	R L B KNEE
	R L B ANKLE
	R L B FOOT

☐	POST-OP JOINT AND SPINE CT SCAN (Metal Artifact Suppression Technique)
	R L Shoulder
	R L Knee
	R L Hip
	R L Spine (Cervical, Thoracic, Lumbar)
	R L Foot/Ankle

☐	ULTRASOUND
	ABDOMEN COMPLETE
	LIVER/GB/PANCREAS (RUQ)
	KIDNEY/BLADDER
	THYROID
	SCROTAL/TESTICULAR
	PELVIC TRANSABD & TRANSVAG
	CAROTID DOPPLER
	AORTA
	R L B LE ARTERIAL DOPPLER
	R L B LE VENOUS DOPPLER
	UE LE MUSCULOSKELETAL STUDY
	ANKLE BRACHIAL INDEX (ABI)
	OB

☐	MR ARTHROGRAM
	R L SHOULDER
	R L WRIST
	R L HIP
	R L KNEE
	R L ( )

☐	X-RAY
	ORBITS for MRI
	CHEST PA & LATERAL
	ABDOMEN KUB (1 view)
	3 5 F/E CERVICAL SPINE
	THORACIC SPINE
	3 5 F/E LUMBAR SPINE
	PELVIS
	R L B HIP
	R L B KNEE
	R L B FOOT
	R L B ANKLE
	R L B SHOULDER
	R L B HAND
	R L B WRIST
	R L B RIBS
	R L B HUMERUS
	R L B ELBOW
	R L B FOREARM
	R L B FEMUR
	R L B TIB - FIB
	R L FINGER/TOES

☐	CT SCAN
	wo w/wo w BRAIN
	wo w/wo w ORBITS
	wo SINUSES
	wo FACIAL BONES
	w/wo w NECK SOFT TISSUE
	wo w CHEST
	w PE CHEST
	wo w/wo w ABDOMEN / PELVIS
	wo RENAL STONE STUDY
	w/wo CT UROGRAM
	CERVICAL SPINE
	THORACIC SPINE
	LUMBAR SPINE
	R L B SHOULDER/ELBOW/WRIST
	R L B HIP/KNEE/ANKLE/FOOT
	3D RECONSTRUCTION
	CT CALCIUM SCORE
	CT ANGIOGRAPHY (CTA)
	CAROTID / NECK CTA
	THORACIC AORTA CTA
	ABDOMINAL AORTA CTA
	LE UE PERIPHERAL CTA
	INTRACRANIAL CTA
	COMMENTS:

☐ PRIORITY READING - Please provide contact telephone number (______________________)