OPEN MRI of Conway

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www.openmriofconway.com

PHYSICIANS ORDER

Saturday & Extended Evening Hours

ACR Accredited

Self Pay Options

Patient Name:_____ DOB:_____/_____/_____ Weight:_____lbs.

Patient Address:_____ CITY/ST/ZIP: _____

Patient Contact #: (_____) _____ - _____ Patient Alt. #: (_____) _____ - _____ Male / Female

MRI OPEN

CONTRAST: ☐ **YES** ☐ **NO**

☐ **BRAIN**
- ☐ WITH ORBITS ☐ WITH IAC'S
- ☐ WITH PITUITARY / SELLA

☐ **MRA**
- ☐ HEAD wo ☐ NECK wo

☐ CERVICAL SPINE
☐ THORACIC SPINE
☐ LUMBAR SPINE
☐ SACRUM
☐ SHOULDER ☐ R ☐ L
☐ HUMERUS ☐ R ☐ L
☐ ELBOW ☐ R ☐ L
☐ WRIST ☐ R ☐ L
☐ HAND ☐ R ☐ L
☐ HIP ☐ R ☐ L
☐ FEMUR ☐ R ☐ L
☐ KNEE ☐ R ☐ L
☐ FOOT ☐ R ☐ L
☐ ANKLE ☐ R ☐ L
☐ PELVIS- BONEY
☐ OTHER _____

_____

_____

PATIENT HISTORY

Does the patient have a history of any of the following:

☐ PACEMAKER
☐ ANEURYSM CLIPS
☐ CURRENTLY PREGNANT
☐ SURGERY WITHIN THE LAST 6 WEEKS
☐ IMPLANTED DEVICES

DIAGNOSIS CODE

CD with patient?

_____ _____

_____ _____

_____ _____

SPECIAL INSTRUCTIONS

_____

_____

_____

_____

_____

Based on the patient's history, exam and diagnosis, I have requested the above listed exam(s). I hereby certify that the exam(s) are medically necessary.

PRINT PHYSICIAN NAME:_____ Phone #:_____

REFERRING PHYSICIAN SIGNATURE:_____NPI #:_____Date:_____/_____/_____

☐ STAT Call Report to: (_____) _____ - _____ ☐ FAX Report to: (_____) _____ - _____