BRIGHAM AND WOMEN'S HOSPITAL

Radiology Scheduling
Telephone: 617 - 732 - 6248
Toll Free: 866 - 345 - XRAY
Hours : 8:00am - 5:00pm, Monday - Friday

MRI REQUISITION

ORDERING PROVIDER INFORMATION			
Ordering Provider	NPI		Ordering Site
Provider's Phone			Provider's Fax
PATIENT INFORMATION			
Patient Name			Date of Birth
Address			Telephone
City	State	Zip	Work/Cell

DOES YOUR PATIENT HAVE THE FOLLOWING?

- ❑ Pacemaker
- ❑ Aneurysm Clips
- ❑ Neurostimulator
- ❑ Cochlear Implant

If your patient has any of the implants listed above, additional information will be requested.

- ❑ Metal fragments or shrapnel in body or eye?
- ❑ Metallic implants, prosthesis, pumps, or cardiac valve?
- ❑ Possibility of pregnancy?
- ❑ Weight greater than 350 pounds?
- ❑ Claustrophobia?
- ❑ Unable to hold still for 30 minutes?
- ❑ Require Sedation (must be prescribed by ordering MD)

LABORATORY RESULTS AND ALLERGIES:

Laboratory Results:
Date: _____
BUN: _____
Creatinine: _____
Diabetic: ❑ Yes ❑ No

Allergies including contrast: ❑ **Yes** ❑ **No**
Please list allergies:
_____
_____

EXAM SELECTION: PLEASE SPECIFY ADDITIONAL EXAM DETAILS

❑ **LEFT** ❑ **RIGHT**

- ❑ Brain, specify _____
- ❑ Temporomandibular Joint _____
- ❑ Facial, specify _____
- ❑ Chest, specify _____
- ❑ Abdomen, specify _____
- ❑ Pelvis, specify _____
- ❑ Knee _____
- ❑ Shoulder _____
- ❑ Upper Extremity, specify _____
- ❑ Lower Extremity, specify _____
- ❑ Breast ❑ Unilateral ❑ Bilateral
- ❑ Neck, specify _____
- ❑ Cervical Spine _____
- ❑ Thoracic Spine _____
- ❑ Lumbar Spine _____
- ❑ Cardiac, specify _____
- ❑ MRA Head _____
- ❑ MRA Carotids _____
- ❑ MRA Peripheral Vessels _____
- ❑ MRI Arthrogram, Specify Joint _____
- ❑ Other _____

PRIMARY DIAGNOSIS:

RELEVENT HISTORY:

INSURANCE INFORMATION:

Insurance Carrier: _____ Policy#: _____
Authorization #: _____

PHYSICIAN SIGNATURE: _____ DATE: _____