MRI Outpatient Testing Order/Appointment Request

Fax to Centralized Scheduling at (606) 408-6816
or call 1-877-304-1935

KING'S DAUGHTERS

*Patient Name:_____ *Date of Order: _____
*Date of Birth: _____ Appointment Needed by: _____
*Primary Phone: _____ Alternate Phone: _____
Ordering Provider (print): _____ *Signature: _____
*Primary Diagnosis Code:_____ *ICD10 Code: _____

** – Indicates required field per CMS guidelines and KDMC policy. Diagnoses must pass medical necessity before the patient's appointment can be scheduled.*

Screening Questions

1. Are you claustrophobic / requesting the open scanner? ☐ Yes ☐ No
2. Do you have a pacemaker or defibrillator? ☐ Yes ☐ No If Yes, is it MR conditional? ☐ Yes ☐ No
3. Have you ever had surgery on the area to be scanned? ☐ Yes ☐ No
4. Have you ever been diagnosed with cancer? ☐ Yes ☐ No If Yes, what type:_____

Anesthesia

Is the procedure to be performed under anesthesia? ☐ Yes ☐ No

MRI *Please check the appropriate procedure box and circle the contrast option.*

HEAD

- ☐ Head W/O *(contrast if necessary)*
- ☐ Head W&W/O
- ☐ IACs W/O W&W/O
- ☐ Orbits/face/neck W/O W&W/O
- ☐ Pituitary W/O W&W/O
- ☐ Spectroscopy
- ☐ Other: _____

SPINE

- ☐ Cervical W/O *(contrast if necessary)*
- ☐ Cervical W&W/O
- ☐ Thoracic W/O *(contrast if necessary)*
- ☐ Thoracic W&W/O
- ☐ Lumbar W/O *(contrast if necessary)*
- ☐ Lumbar W&W/O
- ☐ Other: _____

BODY

- ☐ Abdomen *(liver/spleen/kidney)* W&W/O
- ☐ Pelvis or Sacrum W/O W&W/O
- ☐ MRCP *(pancreas)* W/O W&W/O
- ☐ Breast W/O w/Cad W&W/O
- ☐ Adrenals W/O
- ☐ Chest W&W/O
- ☐ Cardiac Morph W&W/O W/VFM
- ☐ Other: _____

UPPER EXTREMITY

- ☐ Shoulder __ R __ L W/O W&W/O
- ☐ Humerus __ R __ L W/O W&W/O
- ☐ Elbow __ R __ L W/O W&W/O
- ☐ Forearm __ R __ L W/O W&W/O
- ☐ Wrist __ R __ L W/O W&W/O
- ☐ Hand __ R __ L W/O W&W/O
- ☐ Arthrogram __ R __ L
- ☐ Other: _____

LOWER EXTREMITY

- ☐ Hip __ R __ L W/O W&W/O
- ☐ Thigh __ R __ L W/O W&W/O
- ☐ Tib/Fib __ R __ L W/O W&W/O
- ☐ Knee __ R __ L W/O W&W/O
- ☐ Ankle __ R __ L W/O W&W/O
- ☐ Foot __ R __ L W/O W&W/O
- ☐ Arthrogram __ R __ L
- ☐ Other: _____

MRA *Please check the appropriate procedure box and circle the contrast option.*

- ☐ Head W/O W&W/O
- ☐ MRV head W/O W&W/O
- ☐ Neck (carotids) W/O W&W/O
- ☐ Chest W/O W&W/O
- ☐ Aorta w/bilat lower extremity runoffs W
- ☐ Abdomen (renals/SMA) W/O W&W/O
- ☐ Upper Extremity __ R __ L
- ☐ Other: _____