NEUROimaging MRI REQUEST

CARDIOVASCULAR MRI

SUITE 101 - BOSHELL DIABETES BUILDING, 1808 7th Ave S., B’HAM Ph: (205) 934-9906 FAX: (205) 975-1852

NO CARDIAC PACEMAKERS. NO PUMPS, CALL FOR INSTRUCTIONS

Patient name: ___________________________ Age: _____ Sex: _____
Phone#: __________________________ ___________ MRN#: __________________________

IF PATIENT HAS CARDIAC PACEMAKER, DEFIBRILLATOR, ICD or ANEURYSM CLIP - CALL ATT. PHYSICIAN

AND if "yes" to any of the below questions, call MRI technologist at 934-49906

Cardiac Pacemaker: yes or no
Previous Surgery on Head, Neck, Face: yes or no
Aneurysm Clips: yes or no
Metallic Foreign Body: yes or no

If patient weighs more than 300 lbs., call MRI technologist.

INSURANCE INFO:

Primary Carrier: __________________________ Secondary Carrier: __________________________
Policy Holder: __________________________ Policy Holder: __________________________
Policy #: __________________________ Policy #: __________________________
Group #: __________________________ Group #: __________________________

Precertification required?: Yes _____ No _____

AUTHORIZATION#

Attending MD: __________________________ Referring MD: __________________________

SEND REPORT TO: DR. __________________________ at __________________________

Clinical Indication:

ICD9: __________________________

Must support use of magnetic resonance imaging

EPILEPSY

_______ MRI Brain - Neuro Screen
_______ Temporal Lobe
_______ Extratemporal Lobe
_______ Other

_______ Post-Op
_______ MEG protocol
_______ Contrast Injection followed by 3D Volume

TUMOR

_______ MRI with & without contrast - Tumor Protocol
_______ MEG Protocol

_______ Frame or Stealth Protocol
_______ Other

_______ Contrast Injection followed by 3D Volume

VASCULAR

_______ MRI Brain - Vascular Protocol
_______ Intracranial MRA
_______ Extracranial MRA

_______ Aortic Arch MRA
_______ Other

HEADACHES

_______ MRI Brain WITH contrast
_______ MRI Brain WITHOUT contrast

DEMENTIA / MEMORY

_______ Neuroscreen
_______ Temporal Lobe
_______ WITH contrast

ORDERED BY: __________________________ Phone: __________________________

Date Scheduled: __________________________ Time: __________________________

To

1. Complete request form.
2. Call 934-49906 to schedule date & time. Give map to patient to the: BOSHELL BUILDING
7th Avenue S. & 18th Street. Entrance across alley from Patient Discharge.
3. After precertification is complete, fax request to 975-1852. rev. (10-1-2002)