North Shore LIJ Huntington Hospital

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MRI SERVICE ORDER FORM

Patient Name: ________________________________ Today's Date: ________________

Referring Physician: ___________________________ Doctor's Phone: _____________

Patient History/Diagnosis: ____

☐ W/GADOLINIUM CONTRAST

☐ Breast ☐ Right ☐ Left
☐ Carotid
☐ Sinuses
☐ Temporal Mandibular Joint
☐ Neck (Soft Tissue)
☐ Brachial Plexus
☐ C-Spine
☐ T-Spine
☐ L-Spine
☐ Lumbar Plexus
☐ Chest
☐ Abdomen
☐ Liver ☐ MRCP ☐ Pancreas ☐ Kidney
☐ Pelvis
  ☐ Pelvis Organ ☐ Orthopedic
☐ Cardiac
☐ Specify __________________________

☐ MR ARTHROGRAM

☐ Brain
☐ Internal Auditory Canal
☐ Posterior Fossa
☐ Pituitary
☐ Orbits
☐ Functional MRI
☐ ______________specify paradigm
☐ DTI

Upper Extremities:

Shoulder	☐ Right	☐ Left
Elbow	☐ Right	☐ Left
Wrist	☐ Right	☐ Left
Hand/Fingers	☐ Right	☐Left

Specify: ______________________

Lower Extremities:

Hip	☐ Right	☐ Left
Knee	☐ Right	☐ Left
Ankle/Hindfoot	☐ Right	☐ Left
Midfoot/Forefoot	☐ Right	☐ Left
Toes	☐ Right	☐ Left

Specify: ______________________

☐ MR ANGIOGRAPHY

☐ W/GADOLINIUM CONTRAST

☐ Brain
☐ Neck (Carotids)
☐ Thoracic Aorta
☐ Arch/Subclavians
☐ Abdominal Aorta Only
☐ Renal Arteries
☐ Mesenteric Arteries
☐ Runoff Lower Extremities
☐ Venogram: ____________________________

Diagnosis Code: ____________________________________

Procedure Code: ____________________________________

Other: ____