Date of Request: ______________________

Requesting Physician: ______________________

Scheduling Contact: ______________________

Physician Phone: ______________________

Physician Fax: ______________________

Patient Information

Name: ______________________ DOB: ______________

Home Phone: ______________ Cell Phone: ______________ Weight: ______________

See bottom of form for requested information to be faxed to 318.692.2292 Height: ______________

MRI

Dx Code: ______________

Description: ______________________

____ MRI Brain
____ MRI Thoracic Spine
____ MRI Lumbar Spine
____ MRI Abdomen**
____ MRI Prostate** (see dashed-line box below)
____ MRI Pelvis**
____ MRI Kidney**
____ MRI Bladder**
____ MRI Knee
____ MRI Ankle
____ MRI Foot
____ MRI Shoulder
____ MRI Elbow
____ MRI Hand
____ MRI Wrist
____ MRCP**
____ MRA Brain
____ MRA Renal**

Any back surgery on area of spine ordered? ___Yes ___No
Does patient have a pacemaker? ___Yes ___No
Does patient have brain aneurysm clips? ___Yes ___No

____With Contrast ____Without Contrast ____With & Without

CT

Dx Code: ______________

Description: ______________________

____ CT Brain
____ CT Sinus
____ CT Neck (soft tissue)
____ CT Cervical Spine
____ CT Thoracic Spine
____ CT Lumbar Spine
____ CT Chest
____ CT Abdomen/Pelvis**
____ CT Pelvis**
____ CT Abdomen**
____ CTA Abdomen**
____ CT Other (Please specify)

____

Oral Contrast Administration needed?
(For Abdomen/Pelvis and Abdomen scans only)
___ Yes ___ No

____With Contrast ____Without Contrast ____With & Without

Please provide the following if available: (for MRI Prostate scans only) Most recent PSA score: _________ Gleason score: _______
Previous MRI? ___Yes ___No Last MRI date: ____________ Active surveillance? ___Yes ___No

Contrast Details

Complete this entire box if the patient is receiving contrast.

Hx of Hypertension? ___Yes ___No
Hx of Diabetes? ___Yes ___No
Is the patient on Metformin? ____Yes ____No
Hx of Renal / Kidney Disease? ___Yes ___No

Hx of hepatic disease, liver transplant or pending liver transplant? ___Yes ___No
If answered yes to any question in this box, creatinine level from the last 30 days required: _____MG/DL

All patients over 60 years of age, regardless of renal history, must have a creatinine within 30 days of contrasted CT scan.

All results are faxed to the number provided at the top of this form within 1-2 business days, or sooner. If you would like the results faxed to a different number, please provide it: ______________

____
Physician Signature

Please fax this form and the following information to 318.692.2292:

- Demographics
- Insurance Details & Authorization
- Clinicals

Fax Referrals to: 318.692.2292
For scheduling MRI, call: 318.626.1295
For scheduling CT, call: 318.626.4337