PORT HURON

MRI ORDER FORM

Appropriate Use Criteria (AUC)
Vendor: ______________________
AUC #: ______________________
Score: ______________________
Override Reason: ______________
CONF________________

1221 Pine Grove Avenue • Port Huron, Michigan • 48060 • Phone (810) 989-3270 • Fax (810) 987-6342

Patient's Name: ______________________________ DOB:____________________
(First) (Middle Initial) (Last)

Home Phone: ______________________ Cell Phone:______________________

Appointment Date: __________________ Time: ______________ Weight: ______________

ICD-10 Code (Required) ______________________________________

Clinical Signs/Symptoms (Required) ______________________________

ICD-10 Code and clinical history for each test is required to prove medical necessity. We cannot accept a diagnosis that includes the terms "probable", "possible", "suspected", "rule out", or "questionable".

Physician Name: ______________________________Office Phone: ( ) ______________

Physician Signature (Required):______________________Office Fax: ( ) ______________

Description	Without Contrast	Without & With Contrast
HEAD		
Brain	☐	☐
Pituitary	N/A	☐
IAC	N/A	☐
Orbits	N/A	☐
Soft Tissue Neck	N/A	☐
TMJ	☐	N/A
SPINE		
Cervical Spine	☐	☐
Thoracic Spine	☐	☐
Lumbar Spine	☐	☐
Sacrum/Coccyx	☐	☐
Lumbar Plexus	☐	☐
BODY		
Liver	N/A	☐
Kidneys	N/A	☐
Adrenals	N/A	☐
Pancreas	N/A	☐
MRCP	☐	N/A
Screening Abdomen	☐	☐
Pelvis	☐	☐
Chest	☐	☐
Prostate	N/A	☐
BREAST		
Breast/Unilateral		
Right ☐ Left ☐	☐	☐
Breast/Bilateral	☐	☐
☐ **Creatinine Level (if warranted)**		

Description		
EXTREMITIES/JOINTS		
Hand	Right ☐	Left ☐
Wrist	Right ☐	Left ☐
Forearm	Right ☐	Left ☐
Elbow	Right ☐	Left ☐
Humerus	Right ☐	Left ☐
Shoulder	Right ☐	Left ☐
☐ With Arthrogram		
Brachial Plexus	Right ☐	Left ☐
Foot	Right ☐	Left ☐
Ankle	Right ☐	Left ☐
Tibia/Fibula	Right ☐	Left ☐
Knee	Right ☐	Left ☐
Femur/Thigh	Right ☐	Left ☐
Hip	Right ☐	Left ☐
SI Joint	Right ☐	Left ☐

MRA	
MRA Head/Brain	☐
MRA Neck/Carotids W/O & W Contrast	☐
MRA Chest	☐
MRA Abdomen/Renal W/O & W Contrast	☐
MRA Pelvis	☐
Run Off Lower Extremities	☐
Other	

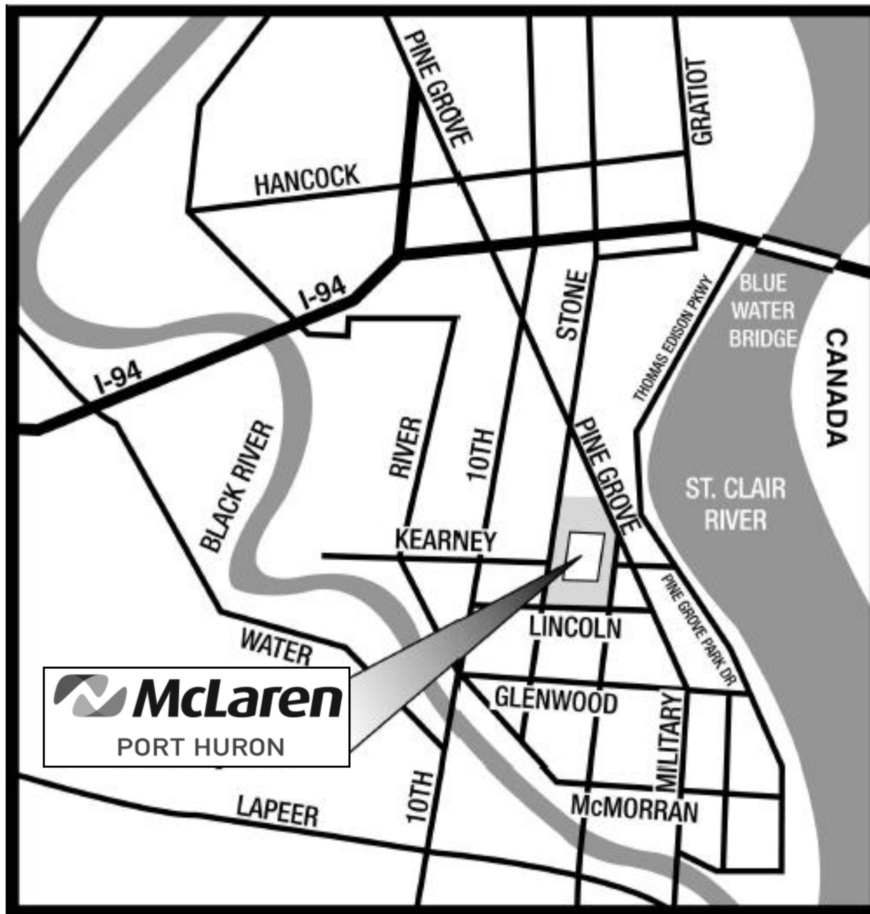
OTHER

(Be Specific)

You must bring this prescription with you on the day of your appointment. Exam cannot be completed without it.

Patient Instructions

- Most exams require no preparation. You may eat, drink, and take medications prior to your test. **(MRI Pancreas and MRCP require no eating or drinking 6 hours prior to test).**
- **MRI Prostate:** Nothing to eat 12 hours before scheduled time of exam. No dairy or carbonated drinks, Clear liquids are fine. You will need to take a GAS-X pill the night before the exam and one pill the morning of the exam. (These are available over the counter at any pharmacy).
- **You will be required to change into hospital-provided clothing prior to your exam.**
- You will be asked to place everything you brought with you into a locker during the exam. (Jewelry, watches, credit cards, piercings, dentures, wigs, and hairpins).
- Patients with **cardiac pacemakers** or **some implanted devices cannot be scanned** because the MRI uses a large magnetic field.
- If you have a history as a metalworker or have metal objects implanted in your body either by surgical procedure (such as stent replacement) or accident (such as shrapnel or metal shavings), please notify MRI personnel when scheduling your appointment.
- Please bring this order form to your appointment and any pertinent X-Rays, CAT scan, Ultrasound, Nuclear Medicine, or MRI films/CD.
- **Please bring your picture ID and insurance card with you the day of your appointment.**



4/2017