# MRI Lincoln Imaging Center

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Patient Name: _____ Phone Number: _____

Signs, Symptoms, Diagnosis: _____

Special Instructions: _____ (RQI#) _____

## MAGNETIC RESONANCE IMAGING/MRI

HEAD
- ( ) **Brain**
- ( ) **Brain/IAC's**
- ( ) **Brain/Stem**
- ( ) Orbits
- ( ) Pituitary
- ( ) Posterior Foss
- ( ) Sinuses

SPINE
- ( ) Cervical Spine
- ( ) Thoracic Spine
- ( ) Lumbar Spine

- ( ) NECK
- ( ) ABDOMEN
- ( ) PELVIS

- ( ) KNEE
- ( ) SHOULDER
- ( ) HIP
- ( ) ANKLE
- ( ) ACHILLES
  - ( ) LEFT
  - ( ) RIGHT
  - ( ) BOTH

OTHER JOINT: _____

_____

OTHER EXTREMITY:

☐ without contrast
☐ with and without contrast

## MRI SCREENING

| | | |
|---|---|---|
| Patient Pregnant | ( ) Yes | ( ) No |
| Metallic Implants | ( ) Yes | ( ) No |
| Cardiac Pacemaker | ( ) Yes | ( ) No |
| Aneurysm Clip in Brain | ( ) Yes | ( ) No |
| Shrapnel | ( ) Yes | ( ) No |

## MRA/ANGIOGRAPHY

- ( ) Carotids
- ( ) Circle of Willis
- ( ) Aorta
- ( ) Renal
- ( ) Other _____

## CAT SCAN/SPIRAL

- ( ) Chest
- ( ) Abdomen
- ( ) Pelvis
- ( ) Neck (Soft Tissue)
- ( ) Other(Specify) _____

☐ without contrast
☐ with and without contrast

- ( ) Head
- ( ) Orbits
- ( ) Sinuses
- ( ) Landmarx Image Guided CT Axial & Coronial Study no Infusion (Additional View of Meatus & Sinuses)

- ( ) Mandible
- ( ) Maxilla
- ( ) Temporal Bones
- ( ) Cervical Spine

- ( ) Lumbosacral Spine
- ( ) Thoracic Spine
- ( ) Specify Level: _____ _____
- ( ) Heart Scan (Coronary Artery Scoring)

***Please Read Special Indications on the back side**

## CT SCREENING

| | | |
|---|---|---|
| Patient Pregnant | Y | N |
| Allergic to Contrast | Y | N |
| Allergic to Seafood | Y | N |
| Kidney Problems | Y | N |
| Heart Problems | Y | N |
| High Blood Pressure | Y | N |
| Diabetes | Y | N |

*Bun/Creat results required before test

## OTHER TESTS

- ( ) QCT Bone Densitometry
- ( ) Holter monitoring
- ( ) Echocardiogram
- ( ) Stress Echo
- ( ) Ultrasound
- ( ) X-RAY

- ( ) EKG
- ( ) EMG/NCV

Please indicate area/procedure

_____

## NUCLEAR MEDICINE

- ( ) Bone Scan
- ( ) 3-Phase Bone Scan
- ( ) Lung Scan
- ( ) Renal Scan
- ( ) G.I. Scan
- ( ) Thyroid Scan
- ( ) Thyroid Scan and Uptake

- ( ) Plain Treadmill
- ( ) Stress Test
- ( ) Thallium Tm/Myoview
- ( ) Gallium Scan
- ( ) Muga
- ( ) Testicular
- ( ) Parathyroid
- ( ) Thyroid Therapy

- ( ) Technetion Ceretec
- ( ) Hida Scan
- ( ) Other _____ _____

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Requested by Dr.: _____

Phone: _____ Fax: _____

Physician's Signature: _____

Appointment Date: _____

Time: _____

| | | |
|---|---|---|
| Give CD to Patient | YES | NO |
| Give Films to Patient | YES | NO |
| Deliver Films to the Doctor's Office | YES | NO |

**Radiology M.D. Reading** ☐ **D.P.M. Reading** ☐
**Radiology D.C. Reading** ☐ **Neuro Reading** ☐

24 hour cancellation required by patient or fee will be applied