MRI Lincoln Imaging Center

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Phone (773) 248-7100 • Fax (773) 248-1210

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 _____ _____

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