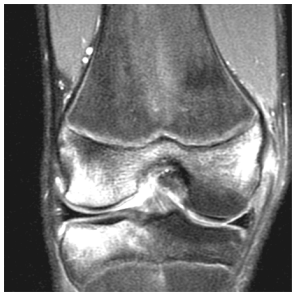
NEWTON-WELLESLEY HOSPITAL



MRI Orthopedic Requisition

MRI scheduling: CALL: 617-243-6217
FAX: 617-243-5563

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

Required Information:

Patient Name _____ Date of Birth |__|__|__|__|__|__|__|__|

Home Phone _____ Authorization # _____

Billing Information: ❒ Health ❒ MVA ❒ W/C ❒ Other _____ Medical Record # |__|__|__|__|__|__|__|__|

Insurance Carrier _____ Policy # _____

Physician Name _____ Phone _____

Clinical History (ICD-Diagnosis Code) _____

_____

_____

Signs/Symptoms: ❒ Shoulder Pain ❒ Extremity Weakness ❒ Back Pain ❒ Leg Pain ❒ Neck Pain
❒ Radiculopathy ❒ Abnormal Radiographs ❒ Mass ❒ Arm Pain ❒ Swelling

Other _____

_____

Prior Surgery or Arthroscopy? *(Please specify)* _____ *Date* _____

EXAM TYPE *(Please check)*

EXTREMITY:
Joint:
❒ Hand *(Left / Right)*
❒ Wrist *(Left / Right)*
❒ Elbow *(Left / Right)*
❒ Shoulder *(Left / Right)*
❒ Hip *(Left / Right)*
❒ Knee *(Left / Right)*
❒ Ankle/hindfoot *(Left / Right)*
❒ Forefoot *(Left / Right)*

❒ **with MR Arthrogram**

Long Bone:
❒ Thigh/Femur *(Left / Right)*
❒ Lower Leg *(Left / Right)*
❒ Forearm *(Left / Right)*
❒ Upper Arm *(Left / Right)*

SPINE:
❒ Cervical
❒ Thoracic
❒ Lumbar
❒ Sacrum/Coccyx
❒ Spine Metastatic Survey

PELVIS:
❒ Bony Pelvis

OTHER: _____
(Please specify)

IV Gadolinium: ❒ Yes ❒ No ❒ CD Copy Requested

This order includes authorization to perform an orbital x-ray and/or serum creatinine, if necessary based on patient history and NWH Radiologist guidelines and review.

Appointment Date / Time _____

MD Signature: _____ Date: _____