



MRI NEUROLOGY REQUISITION

**MRI Scheduling: CALL: 617-243-6217
FAX: 617-243-5563**

Patient Name: _____ Date of Birth: _____
 Date: _____ MM/DD/YYYY
 Home Phone: _____ Medical Record # _____
 Insurance Carrier: _____ Policy # _____
 Billing Information: Health MVA W/C Other _____ Authorization # _____

Physician Name _____ Phone: _____
 MD Signature _____ Date: _____
 Clinical History ICD-Diagnosis Codes: _____

** PLEASE SELECT THE INDICATIONS BELOW, IF THE SYMPTOM IS NOT LISTED BELOW FILL IT IN ON THE ABOVE LINE

Brain:	Contrast	
Brain Routine	Y	N
IAC	Y	N
Pituitary	Y	N
Follow-up MS	Y	N
Temp. Lobes	Y	N
Indications:		
Aneurysm		
Aphasia		
Ataxia		
Cerebral degenerative dz		
Concussion mild or moderate		
Congenital brain malform		
Convulsions, new or prog		
Coordination changes		
Cranial nerve palsy		
Diplopia		
Dizziness		
Dementia		
Epilepsy		
Hearing loss		
Hyperprolactinemia		
Infection of CNS		
Syncope/fainting		
MS, new neurologic event		
MS, newly diagnosed		
Neoplasm - CNS primary		
Neoplasm - non CNS primary		
Neoplasm - Primary unknown		
Migraine		
Pituitary gland dysfunction		
TIA w/ transient neuro disturbance		
Tinnitus		
Stroke		
Vision disturbances		
Weakness rt/lt side or both		

MRA:	Contrast	
Brain & Neck	Y	N
Neck(carotids)	Y	N
Brain only	Y	N
MRA/MRV	Y	N
Thoracic Aorta	Y	N
Indications:		
Aneurysm		
Carotid Stenosis		
Diplopia		
Dizziness		
Localized visual field defect		
Migraine		
Stroke		
Syncope		
Tinnitus		
TIA		
Transient visual loss		
Trigeminal nerve disorder		

Soft Tissue Neck	Y	N
Face- Orbit	Y	N
TMJ		
Indications:		
Congenital abnormalities		
Difficulty opening mouth		
Enlarged Lymph node		
Eye movement abnormal		
Facial fracture		
Fever of unknown origin		
Hearing changes		
Hearing loss (sensorineural)		
Mass Neck		
Mass Skull base		
Neoplasm - Primary unknown		
Neoplasm - Specify primary		
Pain-Head/Neck		
Pain-Throat		
S/p Carotid endarterectomy		
Sinusitis/face pain		
Speech difficulty		
Speech or voice changes		
Swelling of face/orbits		
Thyroid disease		
Tinnitus		
TMJ pain		
Vision changes		

Spine:	Contrast	
Cervical	Y	N
Thoracic	Y	N
Lumbar	Y	N
Cord MS Survey	Y	N
(C&T spine only)		
Spinal Metastatic	Y	N
Indications:		
Abnormal extremity reflexes		
Abnormal extremity sensation		
Abnormal radiographic survey		
Back pain		
Back pain, prior surgery		
Cauda equina syndrome		
Congenital spine malformation		
Demyelinating dz w/spinal cord		
Extremity weakness		
Neck pain		
Neoplasm - Primary unknown		
Neoplasm - specify		
Osteoporosis		
Radiculopathy		
Sciatic leg pain		
Spinal stenosis		
Spine fracture		
Spine infection		
Swelling, mass or lump		

Plexus:	Contrast	
Brachial	Y	N
Lumbar/Sacral	Y	N
Indications:		

Other _____

This order includes authorization to perform safety screening orbital x-ray or serum creatinine, if indicated by patient history.

Appointment Date and Time _____

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