

CT, MRI and MRA
Order / Pre-Authorization Form

Please complete this form for CT, MRI & MRA exams. If the facility changes OR the appointment falls after the Expiration Date, the authorization must be edited.

Patient Name: _____ Date: _____

DOB: _____ MR #: _____

Ordering provider: _____ Billing provider: _____

Insurance: _____ ID #: _____ Phone #: _____

Diagnosis/ICD-9 Code: _____ Hosp/Facility: _____

Was this an injury? No Yes If yes, type of injury: WC MVA Other Date of injury: _____**Clinical history** (Why are you ordering this exam? What are you trying to R/O?): _____

How long has patient had these symptoms? _____

Medications patient is taking pertinent to this DX: _____

Does patient have a contrast allergy? _____

MRI PATIENTS ONLY (please ask ALL of the following questions):Have Metal implants? No Yes Ever worked with Metal? No Yes Weight: _____HX of Claustrophobia? No Yes If yes, Rx needed: _____

Describe HX of Cancer or Surgery: _____

CT PATIENTS ONLY (please ask ALL of the following questions):Diabetic? No Yes Take Glucophage? No Yes HX of Renal failure? No YesAsthma? No Yes ALLERGIES to Shellfish or Iodine? No Yes HX of Kidney disease? No Yes**Any prior imaging studies?** No Yes Type of study: _____**Results:** Negative Positive Explain positive finding: _____

Please check all that apply:

1) TEST REQUESTED:	<input type="checkbox"/> MRI	<input type="checkbox"/> MRA	<input type="checkbox"/> CT
2) TIMEFRAME NEEDED:	<input type="checkbox"/> Today	<input type="checkbox"/> Within 3 days	<input type="checkbox"/> More than 3 days

<input type="checkbox"/> Abdomen/Pelvis	<input type="checkbox"/> Brain	<input type="checkbox"/> Brachial Plexus	<input type="checkbox"/> Facial Bones	<input type="checkbox"/> Enterography	<input type="checkbox"/> Head
<input type="checkbox"/> Abdomen/Kidney Stones	<input type="checkbox"/> IAC's	<input type="checkbox"/> MRCP	<input type="checkbox"/> Mastoid	<input type="checkbox"/> Neck (for carotid)	<input type="checkbox"/> Orbits
<input type="checkbox"/> Breast Biopsy (Nashua)	<input type="checkbox"/> Breast	<input type="checkbox"/> Pituitary	<input type="checkbox"/> Sinus	<input type="checkbox"/> Neck (for soft tissue)	<input type="checkbox"/> TMJ's
<input type="checkbox"/> S-C Joints	<input type="checkbox"/> C-Spine	<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> Chest	

Please check all that apply:

EXTREMITY:	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Bilateral
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<input type="checkbox"/> Ankle	<input type="checkbox"/> Clavicle	<input type="checkbox"/> Elbow	<input type="checkbox"/> Femur	<input type="checkbox"/> Finger	<input type="checkbox"/> Foot
<input type="checkbox"/> Forearm	<input type="checkbox"/> Hand	<input type="checkbox"/> Hip	<input type="checkbox"/> Humerus	<input type="checkbox"/> Knee	<input type="checkbox"/> Lower Leg
<input type="checkbox"/> Scapula	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Sternum	<input type="checkbox"/> Toe	<input type="checkbox"/> Wrist	

For Radiology Use Only:

Patient notified: _____ Order faxed to Radiology: _____ Test date: _____

Booked: FU w/provider _____ Appt. in DH4: _____ Added to CIS Task List: _____

PRE-AUTHORIZATION #: _____ EXPIRATION DATE: _____

TYPE OF STUDY APPROVED: _____