SISKIYOU imaging

NPI# 1700833472

MRI / MRA Scheduling Form

Patient name: _____ Phone:_____ DOB___ / ___ / ___

Indication for exam with ICD-9: _____

_____

HEAD & NECK

☐ BRAIN ☐ BRAIN & ORBITS ☐ ORBITS ONLY ☐ PITUITARY ☐ IAC
☐ SOFT TISSUE NECK ☐ BRACHIAL PLEXUS ☐ BRAIN W/SPECTROSCOPY

SPINE

☐ CERVICAL ☐ THORACIC ☐ LUMBAR ☐ SACRUM/COCCYX ☐ SPINAL CORD SURVEY

EXTREMITY

☐ SHOULDER R/L ☐ ELBOW R/L ☐ WRIST R/L ☐ HAND R/L ☐ FINGER _____
☐ HIP(w/Pelvis) R/L ☐ KNEE R/L ☐ ANKLE R/L ☐ FOOT R/L ☐ OTHER _____
☐ ARTHROGRAM

BODY

☐ CHEST ☐ CHEST WALL_____ ☐ MEDIASTINUM
(site)

BREAST W/ RECONSTRUCTION VIEWS (If personal hx Breast CA: Chest exam also)
☐ IMPLANT ☐ DIAGNOSTIC

☐ ABDOMEN (Please Circle)
GENERAL LIVER SPLEEN BILIARY (MRCP) PANCREAS ADRENAL KIDNEY OTHER_____

☐ PELVIS (Please Circle)
GENERAL MASS SACRAL PLEXUS UTERUS/OVARIES PROSTATE BLADDER OTHER_____

MRA

☐ BRAIN MRA ☐ CAROTID/VERTEBRAL MRA ☐ THORACIC AORTA MRA
☐ ABDOMEN AORTA MRA ☐ PERIPHERAL MRA ☐ OTHER MRA _____

PATIENT SCREENING/PREPARATION

☐ CARDIAC PACEMAKER Y/N *Note-MRI is contraindicated for patients with Pacemakers.
☐ CEREBRAL ANEURYSM CLIPS Y/N *Check with Siskiyou Imaging on type of Clip.
☐ CLAUSTROPHOBIA Y/N *If yes, consider oral sedation prior to MRI study.
☐ COCHLEAR (EAR) IMPLANT Y/N *Check with Siskiyou Imaging on type of Implant.
☐ PREVIOUS SURGERIES - SAME AREA Y/N TYPE: _____
☐ PRIOR FILMS LOCATION: _____
☐ INSURANCE: _____

DOES PATIENT HAVE KIDNEY OR RENAL DISEASE?
☐ Yes ☐ No
If Yes, lab information within last 30 days:
BUN_____ Cr_____ GFR_____

FAX FORM TO SISKIYOU IMAGING @ 488-7529 _____ ___ / ___ / ___
PHYSICIAN/PROVIDER SIGNATURE DATE

_____
PHYSICIAN/PROVIDER PRINTED NAME

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A partnership of Ashland Community Hospital, Rogue Valley Medical Center and Southern Oregon Radiology Associates.