

VCU Medical Center

Virginia Commonwealth University

DEPARTMENT OF RADIOLOGY MRI REQUEST FORM

Date ___/___/___

Patient Name _____

MR # _____ DOB ___/___/___ Age _____

Height _____ Weight _____ Gender M F

Please choose location of where exam is to be performed:

MCV CAMPUS
Phone (804) 628-3580
FAX (804) 628-3593

Ambulatory Care Center (ACC)

Main Hospital - 3rd Floor
1250 E. Marshall St.
Richmond, VA 23298

Basement Level
417 N. 11th. St.
Richmond, VA 23298

STONY POINT MEDICAL CENTER
Phone (804) 237-6645
FAX (804) 327-8847

9000 Stony Point Parkway
Richmond, VA 23235

INSURANCE NAME: _____ PRE-AUTH. # _____ BILL INSURANCE? Y N

STUDY REQUESTED-DIAGNOSIS-INDICATION-REASON FOR STUDY: (print) _____

Please specify if any additional information is desired from this exam: (print) _____

BODY/ABDOMEN (MRI)		HEAD/NECK (MRI) (continued)		CONTRAST
Abdomen (MRCP)		Head/TMJ (Stony Point ONLY)		With Contrast
Chest		Bilateral	Unilateral	Without Contrast
Pelvis (bony)		Internal Auditory Canal (HAC)		With & Without
Pelvis (soft tissue)		Orbital (HOR)		PLEASE ANSWER ALL QUESTIONS (required for scheduling): 1. Sedation? YES <input type="checkbox"/> NO <input type="checkbox"/> 2. Anesthesia? YES <input type="checkbox"/> NO <input type="checkbox"/> 3. Medications? YES <input type="checkbox"/> NO <input type="checkbox"/> (attach if needed): List: _____ 4. Prior Surgery? YES <input type="checkbox"/> NO <input type="checkbox"/> When and where? _____ 5. Claustrophobic? YES <input type="checkbox"/> NO <input type="checkbox"/> 6. ESRD/Dialysis? YES <input type="checkbox"/> NO <input type="checkbox"/> 7. Metal in Body? YES <input type="checkbox"/> NO <input type="checkbox"/> What and where? _____ 8. Pacemaker? YES <input type="checkbox"/> NO <input type="checkbox"/> When and where? _____
MRA—include area of interest		Paratoid/Neck—soft tissue (HNK)		
Head		Posterior Fossa (HPF)		
Abdomen		Sella Turica (HST)		
Neck		Sinus (HSN)		
Extremity	Left Right Bilateral	OTHER:		
OTHER:		EXTREMITY (MRI)		
SPINE (MRI)		Ankle/Foot		
Cervical Spine		Left Right Bilateral		
Thoracic Spine		Extremity - Lower		
Lumbar Spine		Left Right Bilateral		
OTHER:		Hip		
		Left Right Bilateral		
HEAD/NECK (MRI)		Knee		
Brachial Plexis (HNK)		with cartilage sequence		
Head (HED)		Long Bone		
		Left Right Bilateral		
Head/Neck (soft tissue) (HNK)		Shoulder		
		Left Right Bilateral		
Nasopharynx (NAS)		Wrist/Hand		
		Left Right Bilateral		

APPOINTMENT INFORMATION (for Radiology use ONLY)

APPOINTMENT DATE: ___/___/___ TIME: _____ AM PM LOCATION: MAIN 3 ACC STONY POINT

APPOINTMENT MADE BY: _____

Signed order required for scheduling:

Referring Physician Name _____ (print) VM # _____

Referring Physician Signature _____

Contact Name _____ Phone _____ FAX _____ **DRAFT 01-09**