



MRI Orthopedic Requisition

MRI scheduling: CALL: 617-243-6217

FAX: 617-243-5563

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: _____