



To schedule call: 651-229-3995  
 Please complete and fax to: 651-265-7480

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent / Guardian: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Appt. Preference:  Today  Specify, within: \_\_\_\_\_ days \_\_\_\_\_ weeks \_\_\_\_\_ months

Reason for Exam / Medical Necessity / Symptoms & Duration: \_\_\_\_\_

Dx (All indications): \_\_\_\_\_

MRI	
<b>HEAD</b>	
<input type="checkbox"/> Routine	
<input type="checkbox"/> Quick/Shunt Series	
<input type="checkbox"/> Orbit/Face/Sinus	
<input type="checkbox"/> Pituitary	
<input type="checkbox"/> IAC / IAM	
<b>SPINE</b>	
<input type="checkbox"/> Full Spine	
<input type="checkbox"/> Screening	
<input type="checkbox"/> Cervical	
<input type="checkbox"/> Thoracic	
<input type="checkbox"/> Lumbar	
<input type="checkbox"/> L5-S1 (spondylo)	
<input type="checkbox"/> SI Joints	
<input type="checkbox"/> Multi Planar Reconstruction	
<b>ABDOMEN</b>	
<input type="checkbox"/> Kidneys	
<input type="checkbox"/> Adrenals	
<input type="checkbox"/> Liver	
<input type="checkbox"/> MRCP	
<b>THORAX</b>	
<input type="checkbox"/> Sternum	
<input type="checkbox"/> Soft Tissue Neck	
<b>MR ANGIO</b>	
<input type="checkbox"/> Head	
<input type="checkbox"/> Neck	
<input type="checkbox"/> Chest / Pulmonary	
<input type="checkbox"/> Aortic Arch	
<input type="checkbox"/> Renals/SMA	
<input type="checkbox"/> Upper Extremity	
<input type="checkbox"/> Lower Extremity	

MRI	
<b>LOWER EXTR</b>	Specify
<input type="checkbox"/> Full Lower Ext	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Pelvis	
<input type="checkbox"/> Hip	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Hip Quick/Screening	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Femur	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Knee	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Tib / Fib	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Ankle	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Foot	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Toe	Specify Digit: _____
<b>UPPER EXTR</b>	Specify
<input type="checkbox"/> Brachial Plexus	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Shoulder	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Clavicle	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Scapula	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Humerus	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Elbow	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Forearm	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Wrist	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Hand	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilat
<input type="checkbox"/> Finger(s)	Specify Digit: _____
<b>MR ARTHROGRAM</b>	
<input type="checkbox"/> Joint _____	<input type="checkbox"/> Left <input type="checkbox"/> Right
<b>MRI Screening</b>	<b>YES NO</b>
Aneurysm clip	<input type="checkbox"/> <input type="checkbox"/>
Cardiac Pacemaker	<input type="checkbox"/> <input type="checkbox"/>
Cochlear Implant	<input type="checkbox"/> <input type="checkbox"/>
Metal Implant/devices within body	<input type="checkbox"/> <input type="checkbox"/>
Baclofen pump	<input type="checkbox"/> <input type="checkbox"/>
Bivona trach	<input type="checkbox"/> <input type="checkbox"/>
Claustrophobic	<input type="checkbox"/> <input type="checkbox"/>
ADHD or developmental delay	<input type="checkbox"/> <input type="checkbox"/>
Respiratory concerns	<input type="checkbox"/> <input type="checkbox"/>
Programmable shunt	<input type="checkbox"/> <input type="checkbox"/>
Managed by: _____	
Vagus Nerve Stimulator (VNS)	<input type="checkbox"/> <input type="checkbox"/>

**SCHEDULED FOR:**

Date / Time: \_\_\_\_\_

Arrival Time: \_\_\_\_\_

Preparation: \_\_\_\_\_

Pre-Notification #: \_\_\_\_\_

**IV CONTRAST:**

	YES	NO
IV Contrast	<input type="checkbox"/>	<input type="checkbox"/>
Previous contrast reaction (If yes, order prep)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease or Dialysis	<input type="checkbox"/>	<input type="checkbox"/>

**INSTRUCTIONS:**

Allergies: \_\_\_\_\_

MRSA

Ventilator dependent

Pregnant

Child Life Services

Interpreter needed:

Language: \_\_\_\_\_

Previous Images (Non-Gillette):

Location: \_\_\_\_\_ Date: \_\_\_\_\_

**Fax outside Reports to Gillette Imaging: Fax: 651-229-3921**

**Mail CD or film copies to: Gillette Childrens Imaging Dept.**  
 200 University Ave E  
 St. Paul, MN 55101

**SEDATION:** Requires H&P within 7 days

Fax H&P to 651-726-2643

**Other Orders / Instructions:**

  
  
  

Provider Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print/ Stamp here

Phone Number: \_\_\_\_\_ Address: \_\_\_\_\_