Chicago
NORTHSIDE MRI & IMAGING

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PATIENT'S NAME: _____

PATIENT'S PHONE#: _____ DOB: _____

PHYSICIAN: _____

CLINICAL HISTORY/INDICATION: _____

RQI #/Pre-certification: _____

Date: _____

ICD-10: _____

cc/NAME: _____ FAX NUMBER: _____

PHYSICIAN'S SIGNATURE: _____

If clinical decision support (CDS) software utilized, please specify vendor and approval: _____

PERTINENT CLINICAL DIAGNOSIS REQUIRED

PLEASE PROVIDE SPECIFIC ICD-10 CODES AND WHEN POSSIBLE: SYMPTOMS, LOCATION, DURATION, AND PERTINENT PAST HISTORY. (PLEASE DO NOT USE "RULE OUT", "POSSIBLE", ETC.)

COMMENTS: _____

☐ INTRAVENOUS CONTRAST PER RADIOLOGIST (IF YOU DO NOT SELECT THIS OPTION, PLEASE SELECT A CONTRAST OPTION WHERE APPLICABLE.)

☐ ON-SITE BUN/CR TESTING IF NEEDED

MRI

- ☐ wo w/wo BRAIN
- ☐ w/wo IAC'S
- ☐ w/wo PITUITARY
- ☐ w/wo ORBITS
- ☐ wo w/wo CERVICAL SPINE
- ☐ wo w/wo THORACIC SPINE
- ☐ wo w/wo LUMBAR SPINE
- ☐ R L w/wo BRACHIAL PLEXUS
- ☐ wo INTRACRANIAL MRA
- ☐ wo w/wo CAROTID/NECK MRA
- ☐ w/wo THORACIC AORTA MRA
- ☐ w/wo ABDOMINAL AORTA/RENAL MRA
- ☐ w/wo LE PERIPHERAL MRA
- ☐ wo w/wo NECK SOFT TISSUE
- ☐ wo w/wo CHEST

- ☐ wo w/wo **ABDOMEN**
  - ☐ LIVER ☐ PANCREAS/MRCP
  - ☐ RENAL
  - ☐ ABDOMEN OTHER: _____

- ☐ wo w/wo **PELVIS**
  - ☐ BONY ☐ SI JOINTS
  - ☐ UTERUS/OVARIES
  - ☐ PROSTATE
  - ☐ HERNIA PROTOCOL
  - ☐ SOFT TISSUES SPECIFY: _____

ULTRASOUND

- ☐ ABDOMEN COMPLETE
- ☐ LIVER/GB/PANCREAS (RUQ)
- ☐ KIDNEY/BLADDER
- ☐ THYROID
- ☐ SCROTAL/TESTICULAR
- ☐ PELVIC TRANSABD & TRANSVAG
- ☐ CAROTID DOPPLER
- ☐ AORTA
- ☐ R L B LE ARTERIAL DOPPLER
- ☐ R L B LE VENOUS DOPPLER
- ☐ OBSTETRIC
  - ☐ 1st Trimester w EV if needed
- ☐ SOFT TISSUE
- ☐ R L B GROIN

MUSCULOSKELETAL MRI

- ☐ R L HIP ☐ with arthrogram
- ☐ R L SHOULDER ☐ with arthrogram
- ☐ R L ELBOW ☐ with arthrogram
- ☐ R L WRIST ☐ with arthrogram
- ☐ R L HIP OSSEOUS & PELVIS
- ☐ R L KNEE ☐ with arthrogram
- ☐ R L LEG (TIBIA/FIBULA)
- ☐ R L ANKLE/HINDFOOT
- ☐ R L FOREFOOT
- ☐ R L ( )

X-RAY

- ☐ ORBITS for MRI
- ☐ CHEST PA & LATERAL
- ☐ ABDOMEN ☐ SUPINE ☐ SUPINE/UPRIGHT
- ☐ 3 5 F/E CERVICAL SPINE
- ☐ THORACIC SPINE
- ☐ 3 5 F/E LUMBAR SPINE
- ☐ PELVIS
- ☐ R L B HIP
- ☐ R L B KNEE
- ☐ R L B FOOT
- ☐ R L B ANKLE
- ☐ R L B SHOULDER
- ☐ R L B HAND
- ☐ R L B WRIST
- ☐ R L FINGER
- ☐ R L B RIBS
- ☐ R L B CLAVICLE
- ☐ R L B HUMERUS
- ☐ R L B ELBOW
- ☐ R L B FOREARM
- ☐ R L B FEMUR
- ☐ R L B TIB - FIB
- ☐ R L B TOES
- ☐ OTHER:

CT SCAN

- ☐ wo w/wo w BRAIN
- ☐ wo w/wo w ORBITS
- ☐ wo SINUSES
- ☐ wo FACIAL BONES
- ☐ w/wo w NECK SOFT TISSUE
- ☐ wo w CHEST
- ☐ w PE CHEST (CTA)
- ☐ wo w/wo w ABDOMEN / PELVIS
- ☐ wo RENAL STONE STUDY
- ☐ w/wo CT UROGRAM
- ☐ CERVICAL SPINE
- ☐ THORACIC SPINE
- ☐ LUMBAR SPINE
- ☐ R L B SHOULDER/ELBOW/WRIST
- ☐ R L B HIP/KNEE/ANKLE/FOOT
- ☐ 3D RECONSTRUCTION
- ☐ CT CALCIUM SCORE
- ☐ **CT ANGIOGRAPHY (CTA)**
- ☐ CAROTID/NECK CTA
- ☐ THORACIC AORTA CTA
- ☐ ABDOMINAL AORTA CTA
- ☐ LE UE PERIPHERAL CTA
- ☐ INTRACRANIAL CTA
- ☐ COMMENTS:

☐ **PRIORITY READING** - Please provide contact telephone number (_____)