



PHYSICIAN ORDER FORM – MRI Services

To schedule exams, call: 1-800-258-4674

Or fax this form to: 1-800-253-7569

Please include clinical notes with this order

- Auburn, ME
82-3373794
- Boston/Granite Ave.
04-3046812
- Boston/Tufts Medical Center
04-3400617
- Boston/Western Ave.
04-3001031
- Brockton
04-2935687
- Chelmsford
45-2979715
- Dartmouth
04-3043884
- Dedham
04-3046812
- Falmouth
04-2220716
- Framingham
20-2043301
- Greenfield
16-1766731
- Harwich
04-2103600
- Hyannis (CC Hosp.)
04-2103600
- Hyannis (Wilken's Ctr.)
04-2103600
- Leominster
04-3561571
- Lewiston, ME (Central Maine)
01-0211494
- Lowell (Main Campus)
45-2979715
- Lowell (Saints Campus)
45-2979715
- Marlborough
20-2293995
- New Bedford
04-3043884
- Newburyport (AJ Hosp.)
38-3989358
- Palmer
04-3454298
- Portsmouth, NH
02-0501695
- Sandwich
04-2220716
- Springfield
04-3454301
- Topsham, ME
82-3373794
- Wellesley
04-2461479
- West Yarmouth
04-3494613
- Weymouth
04-3046796
- Woburn
46-2523117
- Worcester (Shrews.St.)
04-3454298
- Worcester (Memorial)
04-3454298
- Worcester (University)
04-3454298

| APPT. DATE & TIME | REQUEST |
|-------------------|----------------------------------|
| | <input type="checkbox"/> Routine |
| | <input type="checkbox"/> STAT |

PATIENT INFORMATION

Patient Name: _____ DOB: _____ SSN: _____

Weight: _____ Phone: _____ Cell: _____

Private Health Auto W/C Other: _____ Insurance Co: _____

Subscriber ID: _____ Employer of Policy Holder: _____

Authorization: _____ Valid Dates: _____ Translation Services Needed? **YES NO**

INJURY & PAIN INFORMATION

Diagnosis (ICD-10 codes): _____

Date of Injury: _____ Location of Pain: _____ Severity of Pain (circle): **SEVERE MODERATE MILD**

Mechanism of Injury: _____

History: _____

REFERRING PHYSICIAN INFORMATION

Physician Name: _____ Phone: _____ Address: _____

Office Location (if different): _____ Physician Signature: _____

MRI SCAN INFORMATION

TECHNOLOGY: 1.5T High-field 1.5T High-field Open 3T High-field Open
(3T Sites: Tufts Medical Center; Framingham; Hyannis/Wilken's; Lowell- Saints Campus; Springfield; Weymouth; Woburn; Worcester/Shrewsbury St.)

With and Without Contrast
NOTE: Contrast scans require Creatinine & BUN Level on all patients: (60+ years and/or who have diabetes, hypertension liver or renal disease)

NEUROLOGY
 Brain MRA Brain Brachial Plexus Pituitary MRA Neck (carotid bifurcation) Orbits MRV Brain
 Temporal Bones/IAC Neck/Face Neuroquant 3D icobrain volumetrics Other _____

SPINE
 Lumbar Cervical Thoracic Sacrum Other _____

BODY
 Chest/Thorax Pelvis Abdomen MRCP (biliary) Other _____

BREAST
 Diagnostic Implant Evaluation MRCAD Other _____

MUSCULOSKELETAL
 LEFT **RIGHT**
 Shoulder Ankle Elbow Foot Wrist Thigh Hip Knee Arthrogram
 Other _____

VASCULAR IMAGING
 Chest Aorta Abdominal Aorta Runoff, Lower Ext. Renal Arteries MRV: _____
 Other: _____

Lab Values

Lab Date: _____

Creatinine: _____

GFR: _____

BUN: _____

Prostate

Prostate C-/C+

Reformat for 3D Quantification

Other: _____

PSA Values

Provide 3 most recent PSA values

Date: _____

Value: _____

Date: _____

Value: _____

Date: _____

Value: _____