Shields HEALTH CARE GROUP

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

APPT. DATE & TIME	*REQUEST*
	☐ *Routine*
	☐ *STAT*

☐ Boston/Granite Ave. 04-3046812
☐ Boston/Tufts Medical Center 04-3400617
☐ Boston/Western Ave. 04-3001031
☐ Brockton 04-2935687
☐ Chelmsford 45-2979715
☐ Concord (Emerson Hosp.) 04-2103565
☐ 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)
☐ 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
☐ Westford (Emerson Hosp.) 04-2103565
☐ Weymouth 04-3046796
☐ Winchester (Highland Ave.) 46-2523117
☐ Woburn (Unicorn Park) 46-2523117
☐ Worcester (Shrews.St.) 04-3454298
☐ Worcester (Memorial) 04-3454298
☐ Worcester (University) 04-3454298

PATIENT INFORMATION

Patient Name: _____DOB: _____ Weight: _____

Phone: _____ Cell: _____ Translation Services Needed? *YES* *NO*

☐ Private Health ☐ Auto ☐ W/C ☐ Other: _____Insurance Co: _____

Subscriber ID: _____ Authorization: _____Valid Dates: _____

INJURY & PAIN INFORMATION

Diagnosis (ICD-10 codes): _____

Date of Injury: _____ Location of Pain: _____

History and symptoms: _____

REFERRING PHYSICIAN INFORMATION

Physician Name: _____Phone: _____ Address: _____

Office Location (if different): _____Physician Signature: _____

MRI SCAN INFORMATION

TECHNOLOGY: ☐ 1.2T High-field Open ☐ 1.5T High-field ☐ 1.5T High-field Open ☐ 3T High-field Open

(3T Sites: Dartmouth, Tufts Medical Center; Framingham; Hyannis/Wilken's; Lowell- Saints Campus; Springfield; Weymouth; Woburn; Worcester/Shrewsbury St.; W. Yarmouth)

☐ 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 ico**brain** 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: _____