APPOINTMENT CENTRAL MAGNETIC RESONANCE IMAGING (MRI) PHYSICIAN ORDERS

Patient Information

Last Name	First Name	MI	DOB	SEX M F
Street Address			Home Phone:	
City	State	Zip	Cell Phone: Other Contact Phone:	

***MRI and MRA exams may require Pre certification Prior Authorization or be subject to Medical Necessity**

Insurance Provider	Policy Number	Subscriber Name
Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent		Pre-Certification/ Approval #
Special Instructions Comment		Appointment DAY- DATE- TIME

If MRI exam ordered with contrast, and NO recent Creatinine value, please obtain appropriate Creatinine for GFR, (see recommendations on back pg)

Is Patient in Acute Renal Failure? ☐ Yes ☐ No Serum Creatinine:________ mg/dL Date: ________

Creatinine value (within last 6 weeks)? ☐ Yes ☐ No Creatinine Clearance:________mL/min Date: ________

Pacemaker, Pacing Wires, ICD	☐ Yes	☐ No	Neurostimulators	☐ Yes	☐ No
Brain Surgery	☐ Yes	☐ No	Renal Disease	☐ Yes	☐ No
Pregnant	☐ Yes	☐ No	History of Hypertension	☐ Yes	☐ No
Tissue Expanders Implanted	☐ Yes	☐ No	History of Diabetes	☐ Yes	☐ No
Infusion Pumps	☐ Yes	☐ No	Severe Hepatic Disease	☐ Yes	☐ No

Additional Comments:

Current Medications:

1.________	4.________	7.________
2.________	5.________	8.________
3.________	6.________	9.________

Allergies: ☐ No Allergies

Exam *LCD/NCD, or ABN Required Pre-certification or Prior Authorization	Without Contrast	With Contrast	Without then with Contrast	Exam *LCD/NCD, or ABN Required Pre-certification or Prior Authorization	Without Contrast	With Contrast	Without then with Contrast
* Abdomen				* Lower Extremity-other than joint Specify Location			
* Brain and Brainstem				* MRA Head			
* Orbit/Face/Neck				* MRA Neck (Carotid/Vertebral)			
* Cervical Spine				* MRA Spinal Canal			
* Thoracic Spine				* MRA Abdomen			
* Lumbar Spine				* MRA Chest			
* MRCP				* MRA Upper Extremity			
* Temporomandibular Joint				* MRA Lower Extremity			
* Chest/Hilar/Mediastinum				* MRA Pelvis			
* Pelvis				**Breast MR requires Radiologist approval**			
* Upper Extremity-**JOINT**/Specify joint							
* Upper Extremity-other than joint Specify location:				* Bilateral Breast			
*Lower Extremity-**JOINT**/Specify joint				* Unilateral Breast Right ☐ Left ☐			

History / Reason for exam / Signs & Symptoms / ICD9 Code________

Physician Signature:________ **NPI #**________ **Physician Phone #**________

APPOINTMENT CENTRAL SCHEDULING
Phone (603) 598-3323
Fax (603) 578-5058

Place Label Here

PREPRINTED MAGNETIC RESONANCE IMAGING (MRI) PHYSICIAN ORDER

"American College of Radiology (ACR) Screening Recommendations on Gadolinium-Based MR Contrast Agents, Renal Disease Patients and Nephrogenic Systemic Fibrosis (NSF)

"The ACR Contrast Committee and the Subcommittee for MR Safety members now recommends, as of July 2007, pre-screening patients prior to the administration of Gadolinium-Based Contrast Agents (GBMCA).

It is recommended that prior to elective Gadolinium Based MR Contrast Agent (GBMCA) administration, a recent (e.g., last 6 weeks) Glomerular Filtration Rate (GFR) assessment be reviewed for patients with a history of

1. Renal disease (including solitary kidney, renal transplant, renal tumor)

2. Age> 60

3. History of Hypertension

4. History of Diabetes

5. History of severe hepatic disease/liver transplant/pending liver transplant. For patients in this category only, it is recommended that the patient's GFR assessment be nearly contemporaneous with the MR examination for which the GBMCA is to be administered."

http://www.acr.org/SecondaryMainMenuCategories/quality safety/MRSafety/recommendations gadolinium-based

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