MDI MEDICAL DIAGNOSTIC IMAGING

☐ **MDI-Franklin** *(MRI, US, CT & X-Ray)*
3111 W Rawson Ave Ste #105
Fax: (414) 301-4501

☐ **MDI-Greenfield** *(MRI & US)*
6150 W Layton Ave
Fax: (414) 282-4105

☐ **MDI-Milwaukee** *(MRI, US, CT, X-Ray & Fluoro)*
8522 W Capitol Drive
Fax: (414) 847-1820

Phone: 414-282-4100 www.ask4mdi.com

PATIENT INFORMATION

Patient Name (Last)_____(First):_____DOB:_____ ☐M ☐F

Address:_____Phone:_____

City:_____State:_____Zip:_____

☐ Allergies/other risk factors_____☐Claustrophobic (If sedation is requested, a driver is required to and from exam)

INSURANCE/AUTHORIZATION INFORMATION (Please fax front and back of all insurance cards)

☐ Commercial ID/Group #:_____ ☐ Medicare ☐ Medicaid ID #:_____

☐ Workman's Comp Claim #_____ ☐ Other_____

Authorization to be obtained by: ☐ MDI ☐ Referring Provider Auth #_____Exp:_____

TYPE OF EXAM

DIAGNOSIS/ICD-10 Code:_____
(REQUIRED)

Radiography/X-Ray	Radiography of:_____ ☐ **Left** ☐ **Right** ☐ Chest X-Ray 2 view ☐ Abdomen X-Ray (☐ AP view ☐ 2 view) ☐ Scoliosis 2 view ☐ Spine (☐Cervical ☐Thoracic ☐Lumbar) Other or special request:_____
Fluoroscopy/ Interventional	☐ UGI ☐ Small Bowel ☐ Colon ☐ Esophagram ☐ VCUG ☐ OPMS ☐ Arthrogram_____(☐CT ☐MRI) ☐ LP ☐ Aspiration/Biopsy ☐ Steroid Injection Other or special request:_____
MRI ☐ Contrast ☐ No Contrast	☐ Head/Brain ☐ MRA of _____ ☐ Orbits ☐ IAC/Posterior Fossa ☐ Soft Tissue Neck ☐ Chest ☐ Abdomen ☐ Pelvis ☐ Spine (☐Cervical ☐Thoracic ☐Lumbar) ☐ Extremity_____ ☐ Hip ☐ Knee ☐ Shoulder ☐ **Left** ☐ **Right** Other or special request:_____
CT ☐ Contrast ☐ No Contrast	☐ Head ☐ Sinus ☐ Temporal Bones ☐Chest ☐ Neck ☐ Abdomen/Pelvis ☐ Urogram ☐ Myelogram LEVELS _____ ☐ CT Leg Length ☐ Spine (☐Cervical ☐Thoracic ☐Lumbar) ☐ CTA_____ ☐ Extremity_____ ☐ **Left** ☐ **Right** Other or special request:_____ Creatinine Level:_____mg/dL__ Date Performed_____ ***(OPTION: Creatinine draw can be done at MDI)***
Ultrasound	☐ Carotid ☐ Vascular screening/ABI ☐ Abdomen ☐ Pelvis ☐ Transvaginal ☐ Renal ☐ Extremity Arteries ☐ Extremity Veins ☐Thyroid ☐Scrotum ☐ Pylorus ☐ Infant Hips (< 6mos) ☐ Infant Spine Other or special request:_____

PHYSICIAN INFORMATION

Physician Phone:_____Physician Fax:_____ ☐ Send CD with Patient ☐ STAT RESULTS

X

PHYSICIAN'S SIGNATURE **(REQUIRED)** **PLEASE PRINT NAME** **DATE**