MDI MEDICAL DIAGNOSTIC IMAGING

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PATIENT INFORMATION (REQUIRED)

Patient Name (Last):	(First):	DOB:
Phone:		☐ M ☐ F

BILLING INFORMATION

☐	Insurance Company:			Policy #:		Auth #:	
☐	Workman's Comp	Claim #:		Group #:		Exp:	

DIAGNOSIS/SYMPTOMS (REQUIRED)

REASON FOR EXAM OR ICD10 CODE:

MRI (GR, FR, & MKE)

- ☐ Abdomen
- ☐ Brain
- ☐ Chest
- ☐ Hip
  - ☐ RIGHT
  - ☐ LEFT
- ☐ IAC/Posterior Fossa
- ☐ Knee
  - ☐ RIGHT
  - ☐ LEFT
- ☐ MRA:_____
- ☐ MRV:_____
- ☐ Orbits
- ☐ Pelvis
- ☐ Shoulder
  - ☐ RIGHT
  - ☐ LEFT
- ☐ Soft Tissue Neck
- ☐ Spine:
  - ☐ Cervical
  - ☐ Thoracic
  - ☐ Lumbar
- ☐ Other:_____
  - ☐ RIGHT
  - ☐ LEFT

- ☐ No Contrast
- ☐ W & W/O Contrast
- ☐ Radiologist's Discretion

Patients over 60yrs:
- ☐ Creat to be done @MDI or
- ☐ Creat Level:_____mg/dL
  Date drawn:_____

CT (FR & MKE)

- ☐ Abdomen/Pelvis
- ☐ Abdomen
- ☐ Pelvis
- ☐ Chest
- ☐ CTA:_____
- ☐ Head
- ☐ Leg Length (Scanogram)
- ☐ Myelogram LEVELS:_____
- ☐ Neck
- ☐ Shoulder
  - ☐ RIGHT
  - ☐ LEFT
- ☐ Sinus
- ☐ Spine:
  - ☐ Cervical
  - ☐ Thoracic
  - ☐ Lumbar
- ☐ Temporal Bones
- ☐ Urogram
- ☐ Wrist
  - ☐ RIGHT
  - ☐ LEFT
- ☐ Other:_____
  - ☐ RIGHT
  - ☐ LEFT

- ☐ No Contrast
- ☐ W & W/O Contrast
- ☐ Radiologist's Discretion

Patients over 40yrs:
- ☐ Creat to be done @MDI or
- ☐ Creat Level:_____mg/dL
  Date drawn:_____

X-RAY (FR & MKE)

- ☐ Abdomen (1V/KUB)
- ☐ Chest (2V)
- ☐ Foot
  - ☐ RIGHT
  - ☐ LEFT
- ☐ Hand
  - ☐ RIGHT
  - ☐ LEFT
- ☐ Knee
  - ☐ RIGHT
  - ☐ LEFT
- ☐ Scoliosis (2V)
- ☐ Shoulder
  - ☐ RIGHT
  - ☐ LEFT
- ☐ Spine:
  - ☐ Cervical
  - ☐ Thoracic
  - ☐ Lumbar
- ☐ Wrist
  - ☐ RIGHT
  - ☐ LEFT
- ☐ Other:_____
  - ☐ RIGHT
  - ☐ LEFT

INTERVENTIONAL (FR & MKE)

- ☐ Arthrogram:_____
  - ☐ CT ☐ RIGHT
  - ☐ MRI ☐ LEFT
- ☐ Lumbar Puncture
- ☐ Myelogram
  - ☐ Cervical
  - ☐ Thoracic
  - ☐ Lumbar
- ☐ Steroid Injection

ULTRASOUND (FR & MKE)

- ☐ Abdomen
- ☐ ABI
- ☐ Arterial Duplex: Upper or Lower
  - ☐ RIGHT
  - ☐ LEFT
- ☐ Breast (<18yrs)
  - ☐ RIGHT
  - ☐ LEFT
- ☐ Carotid
- ☐ Infant Head (<1yr)
- ☐ Infant Hips (<6mos)
- ☐ Infant Pylorus (<3mos)
- ☐ Infant Spine (<3mos)
- ☐ OB (1st Trimester)
- ☐ Pelvis (<18yrs)
- ☐ Pelvis/Transvaginal (>18yrs)
- ☐ Renal
- ☐ Scrotum
- ☐ Thyroid
- ☐ Venous Doppler: Upper or Lower
  - ☐ RIGHT
  - ☐ LEFT
- ☐ Other:_____

FOR INTERNAL OFFICE USE ONLY:

Protocoled by:_____
Date:_____
Radiologist:_____
NOTES:

PHYSICIAN INFORMATION (REQUIRED)

Physician Phone:	Fax Results To:	☐ SEND CD w/PATIENT	☐ STAT RESULTS
X			
PHYSICIAN SIGNATURE	**PHYSICIAN NAME (PLEASE PRINT)**		**DATE**