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

☐ **MDI-Franklin**
3111 W Rawson Ave Ste #105
Franklin, WI 53132
Fax: (414) 301-4501

☐ **MDI-Greenfield**
6150 W Layton Ave
Greenfield, WI 53220
Fax: (414) 282-4105

☐ **MDI-Milwaukee**
8522 W Capitol Dr
Milwaukee, WI 53222
Fax: (414) 847-1820

PATIENT INFORMATION (REQUIRED)

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

BILLING INFORMATION

☐	Insurance Company:		Policy #:		Group#:	
☐	Workman's Comp	Please see our Workman's Comp Required Information Form on our Website	Auth #:		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/ 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

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:____________________

INTERVENTIONAL (FR & MKE)

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

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