



If you are unable to make your appointment, please call and cancel or it will be considered a No Show, and your appointment will not be rescheduled.

**MDI-Franklin**  
3111 W Rawson Ave  
Franklin, WI 53132  
MRI

**MDI-Greenfield**  
6150 W Layton Ave  
Greenfield, WI 53220  
MRI US X-Ray

**MDI-Mayfair**  
3077 N Mayfair Rd  
Wauwatosa, WI 53222  
MRI CT US X-Ray

Phone: 414-282-4100 Fax: 414-282-4105

**PATIENT INFORMATION (REQUIRED)**

Patient Name (Last):	(First):	DOB:
Phone:		<input type="checkbox"/> M <input type="checkbox"/> F

**BILLING** \*AUC consultation is mandatory for MRI & CT Services starting 1/1/2022 for Medicare.

<input type="checkbox"/> Insurance Company:	Policy #:	Auth #:
<input type="checkbox"/> Worker's Comp	Claim #:	Group #:
		Exp:

**DIAGNOSIS/SYMPTOMS (REQUIRED)**

**REASON FOR EXAM OR ICD10 CODE:**

MRI (All Locations)	CT (Mayfair)	X-RAY (Greenfield & Mayfair)	ULTRASOUND (Greenfield & Mayfair)
<input type="checkbox"/> Abdomen <input type="checkbox"/> Brain <input type="checkbox"/> Hip <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> IAC/Posterior Fossa <input type="checkbox"/> Knee <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> MRA: _____ <input type="checkbox"/> MRV: _____ <input type="checkbox"/> Orbits <input type="checkbox"/> Pelvis <input type="checkbox"/> Shoulder <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Spine: <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Other: _____ <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT  <input type="checkbox"/> No Contrast <input type="checkbox"/> W & W/O Contrast <input type="checkbox"/> Radiologist's Discretion  <u>Patients over 60yrs:</u> <input type="checkbox"/> Creat to be done @MDI or <input type="checkbox"/> Creat Level: _____mg/dL Date drawn: _____	<input type="checkbox"/> Abdomen/Pelvis <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Chest <input type="checkbox"/> CTA: _____ <input type="checkbox"/> Head <input type="checkbox"/> Leg Length (Scanogram) <input type="checkbox"/> Myelogram LEVELS: _____ <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> Sinus <input type="checkbox"/> Spine: <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Temporal Bones <input type="checkbox"/> Urogram <input type="checkbox"/> Wrist <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> Other: _____ <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT  <input type="checkbox"/> No Contrast <input type="checkbox"/> W/ Contrast <input type="checkbox"/> Radiologist's Discretion  <u>Patients over 40yrs:</u> <input type="checkbox"/> Creat to be done @MDI or <input type="checkbox"/> Creat Level: _____mg/dL Date drawn: _____	<input type="checkbox"/> Abdomen (1V/KUB) <input type="checkbox"/> Chest (2V) <input type="checkbox"/> Foot <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> Hand <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> Knee <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> Scoliosis (2V) <input type="checkbox"/> Shoulder <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> Spine: <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Wrist <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> Other: _____ <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT  <b>INTERVENTIONAL (Greenfield &amp; Mayfair)</b> <input type="checkbox"/> Arthrogram: _____ <input type="checkbox"/> CT <input type="checkbox"/> RIGHT <input type="checkbox"/> MRI <input type="checkbox"/> LEFT <input type="checkbox"/> Lumbar Puncture <input type="checkbox"/> Myelogram <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Steroid Injection	<input type="checkbox"/> Abdomen <input type="checkbox"/> Abdomen Limited (RUQ) <input type="checkbox"/> ABI <input type="checkbox"/> Carotid <input type="checkbox"/> Infant Pylorus (<3mos) <input type="checkbox"/> OB (1 <sup>st</sup> trimester) <input type="checkbox"/> OB (2 <sup>nd</sup> trimester - Mayfair Only) <input type="checkbox"/> Pelvis (<18yrs) <input type="checkbox"/> Pelvis/Transvaginal (>18yrs) <input type="checkbox"/> Renal <input type="checkbox"/> Scrotum <input type="checkbox"/> Thyroid <input type="checkbox"/> Venous Doppler: Upper or Lower <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> Other: _____  <b>FOR INTERNAL OFFICE USE ONLY:</b> Protocolled by: _____ Date: _____ Radiologist: _____ NOTES:

**PHYSICIAN INFORMATION (REQUIRED)**

Physician Phone:	Fax Results To:	<input type="checkbox"/> SEND CD w/PATIENT	<input type="checkbox"/> STAT RESULTS
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<b>X</b>		
<b>PHYSICIAN SIGNATURE</b>	<b>PHYSICIAN NAME (PLEASE PRINT)</b>	<b>DATE</b>



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www.ask4mdi.com

