



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-Greenfield**

6150 W Layton Ave
Greenfield, WI 53220

3T MRI, 1.5T MRI, US and X-Ray

☐ **MDI-Mayfair**

3077 N Mayfair Rd
Wauwatosa, WI 53222

3T MRI, CT, US and X-Ray

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

PATIENT INFORMATION (REQUIRED)

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

BILLING

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

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

DIAGNOSIS/SYMPTOMS (REQUIRED)

REASON FOR EXAM OR ICD10 CODE:

MRI (All Locations)

☐ Abdomen
☐ Brain
☐ 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 (Mayfair)

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

☐ No Contrast
☐ W/ Contrast
☐ Radiologist's Discretion

Patients over 40yrs:

☐ Creat to be done @MDI or
☐ Creat Level: _____mg/dL
 Date drawn: _____

X-RAY (Greenfield & Mayfair)

☐ 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 (Greenfield & Mayfair)

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

ULTRASOUND (Greenfield & Mayfair)

☐ Abdomen
☐ Abdomen Limited (RUQ)
☐ ABI
☐ Carotid
☐ Infant Pylorus (<3mos)
☐ OB (1st trimester)
☐ OB (2nd trimester - Mayfair Only)
☐ Pelvis (<18yrs)
☐ Pelvis/Transvaginal (>18yrs)
☐ Renal
☐ Scrotum
☐ Thyroid
☐ Venous Doppler: Upper or Lower
☐ RIGHT
☐ LEFT
☐ Other: _____

FOR INTERNAL OFFICE USE ONLY:

Protocolled by: _____
 Date: _____
 Radiologist: _____
 NOTES:

PHYSICIAN INFORMATION (REQUIRED)

Physician Phone:	Fax Results To:	☐ SEND CD w/PATIENT	☐ STAT RESULTS
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X

PHYSICIAN SIGNATURE

PHYSICIAN NAME (PLEASE PRINT)

DATE



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at an affordable price.

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