

COMMUNITY MRI & CT



110 N. 37th St, Suite 302
 Norfolk, NE 68701
 Phone: 402-379-2810
 Fax: 402-379-4075

Exam Date:

Exam Time:

Today's Date:

Patient Name:

Insurance Co:

Date of Birth:

Auth Number:

Phone Number:

Valid Dates:

Ordering Physician:

Symptoms:

Relevant Prior Films:

PHYSICIAN SIGNATURE:

X-RAYS	Part(s): _____ # Views (optional): _____

CT SCAN			MRI SCAN		
<input type="checkbox"/>	Head		<input type="checkbox"/>	Brain	
<input type="checkbox"/>	Sinuses		<input type="checkbox"/>	Cervical	
<input type="checkbox"/>	IAC		<input type="checkbox"/>	Thoracic	
<input type="checkbox"/>	Soft Tissue Neck	<input type="checkbox"/> Contrast?	<input type="checkbox"/>	Lumbar	<input type="checkbox"/> Contrast?
<input type="checkbox"/>	Chest	(circle one)	<input type="checkbox"/>	Shoulder	(circle one)
<input type="checkbox"/>	Abdomen	With	<input type="checkbox"/>	Elbow	With
<input type="checkbox"/>	Pelvis	Without	<input type="checkbox"/>	Wrist	Without
<input type="checkbox"/>	Cervical	W/o & W/	<input type="checkbox"/>	Pelvis	W/o & W/
<input type="checkbox"/>	Thoracic		<input type="checkbox"/>	Hip	
<input type="checkbox"/>	Lumbar		<input type="checkbox"/>	Knee	
<input type="checkbox"/>	Lower Ext		<input type="checkbox"/>	Ankle	
<input type="checkbox"/>	Upper Ext		<input type="checkbox"/>	Foot	
<input checked="" type="checkbox"/>	Other (specify) _____	CAC score _____	<input type="checkbox"/>	Other (specify) _____	

CT QUESTIONS:			MRI QUESTIONS:		
NPO x 6 hours?	yes	no	Pacemaker?	yes	no
Iodine or shellfish Allergy?	yes	no	Aneurysm Clips?	yes	no
Diabetic ?	yes	no	Body Piercings?	yes	no
Over 60?	yes	no	Welding/Grinding?	yes	no
Labs (within 30 days)			Claustrophobia?	yes	no
Date Drawn:	BUN:	Cr:	Relevant Prior Surgeries?	yes	no

SCHEDULED BY:	Notes:
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