

# UNIVERSITY OF VIRGINIA HEALTH SYSTEM DEPARTMENT OF RADIOLOGY/UVA IMAGING MRI IMAGING REQUEST FORM

PLACE LABEL HERE

Ordering Date \_\_\_\_\_

SS# \_\_\_\_\_

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

Please **Fax** to (434) 243-0307-UVA Imaging @ Fontaine or 243-6999-Hosp East  
**Schedule** at (434) 243-0321-UVA Imaging @ Fontaine or 243-6888-Hosp East

**\*\*\*If Pt has Pacemaker or Cochlear  
Implant, MRI is contraindicated.**

Patient Name: \_\_\_\_\_

Pre/Post-op    Y    N                      Date of Surgery \_\_\_\_\_ MR# \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Weight: \_\_\_\_\_ Phone # \_\_\_\_\_ Date of Test \_\_\_\_\_

Insurance Company & Plan	Pre Authorization Number	Attending MD/Pic #	Ordering MD/Pic #
Referring Clinic/Office Where Report Should Be Sent	Phone Number of Contact Person Name	Box & Fax Number	

**STUDY DESIRED (Circle Side if appropriate)**

X	Study	X	Study
	<u>Common MRI Procedures</u>		
	MRI Brain (*orbit x-ray/3D recon/MRA as medically necessary)		MRI Cardiac (*orbit x-ray/3D recon/MRA as medically necessary)
	MRI Facial Bones/Orbits (*orbit x-ray/3D recon/MRA as medically necessary)		MRI Chest (*orbit x-ray/3D recon/MRA as medically necessary)
	MRI Temporal Bones (*orbit x-ray/3D recon/MRA as medically necessary)		MRI Abdomen (*orbit x-ray/3D recon/MRA as medically necessary)
	MRI Sinus (*orbit x-ray/3D recon/MRA as medically necessary)		MRI Pelvis (*orbit x-ray/3D recon/MRA as medically necessary)
	MRI Soft Tissue Neck (*orbit x-ray/3D recon/MRA as medically necessary)		MRI Upper Extremity LT RT (*orbit x-ray/3D recon/MRA as medically necessary)
	MRI Cervical Spine (*orbit x-ray/3D recon/MRA as medically necessary)		MRI Lower Extremity LT RT (*orbit x-ray/3D recon/MRA as medically necessary)
	MRI Thoracic Spine (*orbit x-ray/3D recon/MRA as medically necessary)		MR Angio Chest # (*orbit x-ray/3D recon/MRI as medically necessary)
	MRI Lumbar Spine (*orbit x-ray/3D recon/MRA as medically necessary)		MR Angio Abdomen # (*orbit x-ray/3D recon/MRI as medically necessary)
	MRI Cisternogram (*orbit x-ray/3D recon/MRA as medically necessary)		MR Angio Pelvis # (*orbit x-ray/3D recon/MRI as medically necessary)
	MR Angio Head # (*orbit x-ray/3D recon/MRI as medically necessary)		MRA Upper Extrem LT RT #(*orbit x-ray/3D recon/MRI as medically necessary)
	MR Angio Neck # (*orbit x-ray/3D recon/MRI as medically necessary)		# MRA exams require a corresponding MRI as part of protocol

**Any Exam Not Listed (Specify):**  
Unless Specified, IV contrast will be decided upon by the Radiologist

**Clinical Indications for Exam (Mandatory):**

**ICD-9 Dx Code(Mandatory):**

**Protocol (Internal Use ONLY):**

**Physician Signature** \_\_\_\_\_

Special considerations:     Non-English speaking     Sz disorder     Pregnancy  
 Other: \_\_\_\_\_

Is Pt Claustrophobic?     Yes     No                      Hx of Metal in Eyes?     Yes     No  
 Is Sedation required?     Yes     No                      (Pediatric/Claustrophobic patients may require sedation)  
 Please check here if you do not wish the Radiologist to determine medical necessity.



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