Baystate Health | Shields HEALTH CARE GROUP

OUTPATIENT CENTER

PHYSICIAN ORDER FORM – MRI Services

To schedule exams, call: 1-800-258-4674
Or fax this form to: 1-800-253-7569

☐ **Baystate MRI & Imaging Center**
80 Wason Ave
Springfield, MA 01107
Phone: 413-730-9200
Fax: 413-732-4771
Tax ID#: 04-3454301
1.5T High Field Open
3T High Field Open

☐ **Baystate Frankin MRI**
164 High Street
Greenfield, MA 01301
Phone: 413-772-1900
Fax: 413-772-2002
Tax ID#: 16-1766731
1.5T High Field Open

☐ **Wing Memorial Hospital**
40 Wright Street
Palmer, MA 01069
Phone: 1-800-258-4674
Fax: 1-800-253-7569
Tax ID#: 04-3454298
1.5T High Field

Note: High Field Open machines accommodate patients up to 550 lbs.

PATIENT INFORMATION

Patient Name: ______________________ DOB: ____________ SSN: ____________________

Weight: _____Phone: ____________ Cell: ________________ Email: _____________________

☐ Private Health ☐ Auto ☐ W/C ☐ Other: ________ Insurance Co: _________________

Subscriber ID: ____________________ Employer of Policy Holder: ________________________

Authorization: ____________Valid Dates: _____________Translation Services Needed? *YES* *NO*

Appt. Date & Time

Request
☐ Routine
☐ STAT

INJURY & PAIN INFORMATION

Diagnosis (ICD-10 codes): ____

Date of Injury: _______ Location of Pain: ____________ Severity of Pain (circle): *SEVERE* *MODERATE* *MILD*

Mechanism of Injury: ____

History: ____

REFERRING PHYSICIAN INFORMATION

Physician Name: ______________ Phone: _______________ Address: ________________________

Office Location (if different): _____________________ Physician Signature: ____________________________

MRI SCAN INFORMATION

☐ 1.5T High-field ☐ 1.5T High-field Open ☐ 3T High-field *(Lowell –Saints' Campus)* ☐ 3T High-field Open *(Hyannis/Wilken's; Woburn; Springfield)*

☐ Without Contrast
☐ With and Without Contrast
NOTE: Contrast scans require Creatinine & BUN Level on all patients· (60+ years and/or who have diabetes, hypertension liver or renal disease)

NEUROLOGY
☐Brain ☐MRA Brain ☐Brachial Plexus ☐Pituitary ☐MRA Neck (carotid bifurcation) ☐Orbits
☐MRV Brain ☐Temporal Bones/IAC ☐Neck/Face ☐Neuroquant ☐Other____________

SPINE
☐Lumbar ☐Cervical ☐Thoracic ☐Sacrum ☐Other____________

BODY
☐Chest/Thorax ☐Pelvis ☐ Abdomen ☐MRCP (biliary) ☐Other____________

BREAST
☐Diagnostic ☐Implant Evaluation ☐MRCAD ☐Other____________

MUSCULOSKELETAL
☐LEFT ☐RIGHT
☐Shoulder ☐Ankle ☐Elbow ☐Foot ☐Wrist ☐Thigh ☐Hip ☐Knee ☐Arthrogram ☐Other_______

VASCULAR IMAGING
☐Chest Aorta ☐Abdominal Aorta ☐Runoff, Lower Ext. ☐Renal Arteries ☐MRV: _____ ☐Other: _____

PELVIC
☐Prostate ☐Other: _________

Lab Values
Lab Date: __________
Creatinine: _________
GFR: ______________
BUN: ______________

Prostate
☐ Prostate C-/C+
☐ Reformat for 3D Quantification
☐ Other: ____________

PSA Values
Provide 3 most recent PSA values
Date: _______ *Value:* ________
Date: _______ *Value:* ________
Date: _______ *Value:* ________