VCU Medical Center
Virginia Commonwealth University
Every Day, A New Discovery.®

Department of Radiology MRI Request Form

Date: ____ / ____ / ______

Patient Name: ______________________________

MR#: ____________ DOB: ____ / ____ / ______ Age: ___

Height: ____ft ____in Weight: ________lbs Gender: M___F___

Requested location for exam:

____ **MCV Campus**
Phone (804) 628-3580
Fax (804) 628-3593

____ **Stony Point Campus**
Phone (804) 237-6645
Fax (804) 327- 8847

Insurance Information Insurance Name: ______________________________

PreAuth#______________________ Bill Insurance? ________Y ________N

Diagnosis Code – Reason for study (please print): ______________________________

____

____

Additional Information? (please print): ______________________________

Spine (MRI)

	Spine (MRI)	Contrast	
	Cervical Spine	__with	__w/o
	Thoracic Spine	__with	__w/o
	Lumbar Spine	__with	__w/o
	Sacrum	__with	__w/o

Head/Neck MRI

	Head/Neck MRI	Contrast	
	Head - ___**MRI** ___**MRA** ___**MRV**	__with	__w/o
	Neck - ___**MRA** ___**MRV**	__with	__w/o
	Orbit	__with	__w/o
	Sella Turcica	__with	__w/o
	Internal Auditory Canal	__with	__w/o
	Posterior Fossa	__with	__w/o
	Sinus	__with	__w/o
	Soft Tissue Neck MRI	__with	__w/o
	Nasopharynx	__with	__w/o
	Parotid	__with	__w/o
	Brachial Plexus ___**L** ___**R** ___**Bi**	__with	__w/o
	TMJ (Stony Point Only) ___**L** ___**R** ___**Bi**	__with	__w/o

____ Other: ______________________________

____ **Extremity MR Arthrogram (indicate one)**

__ Shoulder __Elbow __Wrist ___
__ Hip ___ Other ______________________

Extremity (MRI) - indicate side

	Extremity (MRI) - indicate side				Contrast	
	Shoulder -	___L	___R	___Bi	__with	__w/o
	Humerus -	___L	___R	___Bi	__with	__w/o
	Elbow -	___L	___R	___Bi	__with	__w/o
	Forearm -	___L	___R	___Bi	__with	__w/o
	Wrist -	___L	___R	___Bi	__with	__w/o
	Finger -	___L	___R	___Bi	__with	__w/o
	Hip -	___L	___R	___Bi	__with	__w/o
	Femur/ Thigh -	___L	___R	___Bi	__with	__w/o
	Knee -	___L	___R	___Bi	__with	__w/o
	Tibia/Fibula / Calf -	___L	___R	___Bi	__with	__w/o
	Ankle -	___L	___R	___Bi	__with	__w/o
	Foot -	___L	___R	___Bi	__with	__w/o

Vascular - indicate side

	Vascular - indicate side				Contrast			
	Upper Extremity -	___L	___R	___Bi	__with	__w/o	__MRA	__MRV
	Lower Extremity -	___L	___R	___Bi	__with	__w/o	__MRA	__MRV

____ Vascular Area of Interest ______________

Body/Abdomen (MRI)

	Body/Abdomen (MRI)	Contrast				
	Cardiac	__with	__w/o	__MRI	__MRA	__MRV
	Chest	__with	__w/o	__MRI	__MRA	__MRV
	Abdomen (MRI includes MRCP)	__with	__w/o	__MRI	__MRA	__MRV
	Abd. -Renal (MRI incl MR Urography)	__with	__w/o	__MRI	__MRA	__MRV
	Pelvis (Soft Tissue)	__with	__w/o	__MRI	__MRA	__MRV
	Pelvis (Bony)	__with	__w/o	__MRI	__MRA	__MRV

Please answer all questions (required for scheduling)

1) Pacemaker? ___Yes ___No When & Where?

____

2) Sedation/Anesthesia? ___Yes ___No

3) Claustrophobia? ___Yes ___No

4) ESRD/Dialysis? ___Yes ___No

5) Metal in body?___Yes ___No

6) Prior Surgery? If Yes, please describe. ___Yes ___No

____

____

Appointment Information (Radiology use only)

Date: ____ / ____ / ______ Time: ____:______ ____AM ____PM

Location: ____Main 3 ____ACC ____Stony Point

Appointment made by: ______________________________

Signed Order Required for Scheduling

Ref. Physician Name: ______________________________VM#_______

Ref. Phys. Signature: ________________________ VCUHS ID#_______

Contact Name: ____________________ Phone# (____) ____ - ______

Fax# (____) ____ - ______ VM Location: ____________________

DRAFT 01-12