RADIOLOGY ASSOCIATES OF WAUSAU, S.C.

OPEN MRI OF WAUSAU

Patient name: _____ DOB: _____ Phone: _____

Referring MD: _____ Phone: _____ Fax: _____

Patient History/Symptoms: _____

_____

Previous Related Imaging: _____

Is there any history of contrast reaction? No Yes (If yes, then consider pre-medication)
Is the patient potentially pregnant? No Yes
Is there a history of metal in the eyes/orbits? No Yes (If yes, then include request for x-ray of orbits to screen for metallic foreign body one hour prior to MRI appointment)
Contraindications to MRI: Aneurysm clips? Pacemaker? Defibrillator? Other? _____
Patient Height _____ Weight _____
Prior Surgery in area to be scanned? No Yes (If yes, then describe _____
_____)

A. SITE TO BE IMAGED, CIRCLE THE SPECIFIC LOCATION WITHIN EACH ORGAN SYSTEM -

(___) Abdomen Liver Biliary (MRCP) Adrenal Kidney

(___) Brain Routine IAC Pituitary Pineal

(___) Brain MRA **(___) Carotid MRA**

(___) Chest (plain) Aorta Chest Wall Mediastinum Heart

(___) Extremity Joint(s) (____) Right (____) Left Ankle Elbow Foot Finger/Hand Knee Shoulder Wrist Other - _____

(___) Orbits / Face / Neck **(___) TMJ**

(___) Pelvis Female Pelvic Organs Hips Sacrum Lumbosacral Plexus

(___) Spine Cervical Thoracic Lumbar

(___) Vascular/MRA - Aorta (Thoracic or Abdominal), Pelvis, Renal Arteries, Abdominal Visceral Arteries

(___) Other Please specify _____

B. CONTRAST (circle one): 1. Without 2. Without and With 3. Defer decision to Radiologist

The patient should report to CHC Weston Clinic (4005 Community Center Drive).
Please mail available correlating films to OPEN MRI Scheduling, c/o Radiology Film Tracking, 333 Pine Ridge Blvd, Wausau, WI 54401 and indicate date of OPEN MRI exam.

Important phone numbers: Scheduling – 715-847-2020
After scheduling, please FAX this form to – 715-847-0020 / Attention: Open MRI Scheduling

SCHEDULED DATE: _____ and TIME: _____

Ordering MD Signature:_____Date_____