RADIOLOGY ASSOCIATES OF WAUSAU, S.C.

OPEN MRI OF WAUSAU

www.openmriofwausau.com

Patient Name: _____ D.O.B.: _____ Phone: _____

Referring M.D.: _____ Phone: _____ Fax: _____

Patient History/Symptoms: _____

Previous Related Imaging: _____

Is there any history of contrast reaction? No Yes (If yes, then consider premedication)
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?
Prior Surgery in area to be scanned? No Yes (If yes, then describe _____)
Patient Height: _____ Weight: _____

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

Please mail available correlating films with date of OPEN MRI exam to:

OPEN MRI Scheduling
c/o Radiology Film Tracking
333 Pine Ridge Blvd
Wausau, WI 54401

Important phone numbers: Scheduling – 715-847-2020 or Toll-free 888-616-5611
After scheduling, please FAX this form to – 715-241-5411 / Attention: Open MRI Scheduling
The patient should report to **Aspirus Weston Clinic, 4005 Community Center Drive, Weston, WI**
(Map and directions are available at www.openmriofwausau.com)

Appointment Date: _____ Time: _____

Ordering M.D. Signature: _____ Date: _____