



WISCONSIN RIVER
ORTHOPAEDICS
Relieving pain and restoring lives

OPEN MRI SCHEDULING

Patient Name: _____ DOB: _____ Phone: _____

Ordering MD: _____ Phone: _____ Fax: _____

NPI# _____

Patient History/Symptoms: _____

Do you have a PACEMAKER? DEFIBRILLATOR? ANEURYSM CLIPS? _____

If YES to pacemaker or defibrillator, you CANNOT have an MRI. Only certain aneurysm clips are MRI compatible.

Have you had previous studies for a similar problem? Yes No

Date and Facility (MRI, CT, X-Rays, Ultrasound, Nuclear Medicine, PET scan): _____

Check the appropriate study. Circle the Laterality (R= RIGHT L=LEFT)

- | | | | |
|--|---|---------------------------------------|---|
| <input type="checkbox"/> Shoulder R or L | <input type="checkbox"/> Elbow R or L | <input type="checkbox"/> Wrist R or L | <input type="checkbox"/> Hand/Finger R or L |
| <input type="checkbox"/> Hip R or L | <input type="checkbox"/> Knee R or L | <input type="checkbox"/> Ankle R or L | <input type="checkbox"/> Foot R or L |
| <input type="checkbox"/> Cervical Spine | <input type="checkbox"/> Thoracic Spine | <input type="checkbox"/> Lumbar Spine | <input type="checkbox"/> Pelvis <input type="checkbox"/> Sacrum |

OTHER: Please Specify: _____

Please indicate: Without Contrast Without Contrast and With Contrast

Creatinine Level Y or N Date ordered: _____ Facility: _____ Int: _____

Date of results: _____ Creatinine: _____ eGFR: _____

***If contrast is indicated and patient is over age of 70, diabetic, or hx of kidney/renal disease, Patient will need a creatinine level, within 28days prior to exam.*

***Has patient ever had an allergic reaction to MRI contrast/dye? Y or N Explain : _____*

Orbits X-Ray Orbit X-ray cleared for MRI procedure: Y or N Approved by: _____ Date: _____

MRI Precert/Authorization # _____

The patient should report to the Wisconsin River Orthopaedics - Open MRI located at:
 140 24th St South (the corner of Peach Street and Highway 54), Wisconsin Rapids, WI.
 Phone: 715-424-1881 Fax: 715-424-1898

SCHEDULED DATE: _____ TIME: _____ a.m./p.m.

FOLLOW UP APPT: _____ TIME: _____ a.m./p.m.

Ordering MD Signature**: _____ Date _____

****I approve the use of contrast, orbits x-ray, creatinine if deemed necessary by Physician/Technologist.**