Open MRI at Carolina Orthopedics

Order Form

191 Centre South Blvd
Suite 10
Phone 803-335-2281
Fax 803-937-1706
Email imaging@caroilinaorthopedics.net

Patient Information
Name_____
Address_____
_____
Phone_____
Email_____
D O B_____/_____/_____
Height_____ Weight_____ M/F

Physician Information
Referring Physician_____
Practice Name_____
Fax_____
Phone_____-
Email_____
Diagnosis_____
_____

If covered by Insurance:
Policy name_____
Number_____ Authorization_____

If this is a cash MRI, $400 paid at scheduling includes the report emailed to you and/or your doctor and a copy of the images to you.

Reason for test, brief history_____
_____
_____
_____

Spine	Upper Extremity		Lower Extremity	
Cervical spine	Shoulder	R/L/B	Hip	R/L/B
Lumbar spine	Arm	R/L/B	Thigh	R/L/B
	Elbow	R/L/B	Knee	R/L/B
Sacrum/coccyx	Forearm	R/L/B	Leg	R/L/B
	Wrist	R/L/B	Ankle	R/L/B
	Hand	R/L/B	Foot	R/L/B
	Finger 1/2/3/4/5	R/L/B	Toe 1/2/3/4/5	R/L/B

*note Thumb is 1 and pinky is five Big toe is 1, little toe is 5

If test is ordered by physician or covered by insurance:
Physician's notes (diagnosis code, reason for test, brief history)

Ordering physician's signature_____ Date____/____/_____

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MRI Checklist

Please indicate if you have any of the following	Circle yes or no
If female, are you pregnant or trying to get pregnant	yes/no
Cardiac pacemaker/valve/ stent	yes/no
Brain aneurysm clip/shunt	yes/no
Aortic clip/Shunt	yes/no
Any implanted electronic device	yes/no
Insulin pump/infusion device	yes/no
Hearing aids (please remove prior to MRI)	yes/no
Cochlear implant or other non removable hearing aid	yes/no
Prosthetic device	yes/no
Joint replacements, metal rods, plates, screws, nails, bone anchors	yes/no
Are any less than six weeks old	yes/no
Shrapnel, bullet, or other foreign body	yes/no
Have you had an eye injury involving metal or do you work with metal	yes/no
Tattoos or piercings (please remove piercings prior to MRI)	yes/no
Fainting or dizzy spells (syncope)	yes/no

Please list all allergies or answer none

Have you had any surgery of the heart, brain, spine or abdomen yes/no

If yes, what was done, when and where? _____

_____

_____

Have you had a prior MRI of same body part that is being scheduled? yes/no

If so, where, when and what was found?_____

_____

_____

I (undersigned) understand, and have personally answered all the above questions

_____ ___/___/_____

Signature of patient or guardian date

_____ ___/___/_____

Signature of person conducting this screening date