

University of Texas Health Science Center of Houston, McGovern Medical School
643 I Fannin Street, Ground Floor, Room G. 605, Houston TX 77030

Tel: (713)500-6916 Fax: (713)500-0698

MRI Examination Order Form

Please Fax all orders to (713) 500-0698. Patient will be contacted to schedule an appointment

Patient Information

Patient Name:	DOB:	Age:
Patient MRN:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Contact number:	Patient Email:	
Diagnosis:	ICD-10 Codes:	

Physician Information

Physician Name:	Phone number:
NPI number:	Fax number:
Address:	Fax Number:
City / State / Zip:	
Physician Signature:	Date:

Please check exam required below

Site	<input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> BILATERAL
Contrast	<input type="checkbox"/> Without Contrast <input type="checkbox"/> With Contrast <input type="checkbox"/> With and without contrast
<input type="checkbox"/> Brain	<input type="checkbox"/> Face <input type="checkbox"/> MRA head/neck
<input type="checkbox"/> Brain Pituitary / IAC / Orbits	<input type="checkbox"/> Brachial plexus <input type="checkbox"/> MRA external carotid
<input type="checkbox"/> Internal Auditory canal	<input type="checkbox"/> Shoulder / elbow / wrist <input type="checkbox"/> MRA chest
<input type="checkbox"/> Temporomandibular joint	<input type="checkbox"/> Humerus / forearm / hand <input type="checkbox"/> MRA spinal canal
<input type="checkbox"/> Neck	<input type="checkbox"/> Hip / Knee / ankle <input type="checkbox"/> MRA abdomen
<input type="checkbox"/> Chest	<input type="checkbox"/> Femur / Tib-Fib / Foot <input type="checkbox"/> MRA pelvis
<input type="checkbox"/> Breast	<input type="checkbox"/> Spine cranio-cervical junction <input type="checkbox"/> MRA upper extremity
<input type="checkbox"/> Myocardium	<input type="checkbox"/> Spine cervical <input type="checkbox"/> MRA lower extremity
<input type="checkbox"/> Cardiac MRI limited study	<input type="checkbox"/> Spine lumbar ADVANCED IMAGING (TMC OPID)
<input type="checkbox"/> MR spectroscopy	<input type="checkbox"/> Spine thoracic <input type="checkbox"/> MRI Neurography
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Spine sacrum <input type="checkbox"/> MRI Cartilage imaging
<input type="checkbox"/> Pelvis	<input type="checkbox"/> Spine complete T2 maps / T1 Rho
<input type="checkbox"/> Prostate	<input type="checkbox"/> Other <input type="checkbox"/> MRI 3D models
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Metal reduction (MARS)
<input type="checkbox"/>	<input type="checkbox"/> Other
Special Instruction:	
Comments:	

*Required information for all contrast orders

- Contrast injection X 1 dose via IVP/injector (dose 0.2ml/kg with max dose of 20ml)
- Patient who is ≥ 50 years old and/or with history of kidney disease will need a STAT creatinine done (if serum creatinine has not been performed in the last two weeks).

Physician Signature: _____ Date: _____