Advanced Radiology — MRI

Central Scheduling: 203.337.XRAY (9729)
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High Field Wide-Bore MRI Centers

- ◉ **Fairfield** — 1055 Post Rd., Fairfield, CT 06824
- ○ **Orange** — 297 Boston Post Rd., Orange, CT 06477
- ○ **Trumbull** — 15 Corporate Dr., Trumbull, CT 06611
- ○ **Stamford** — 1259 East Main St., Stamford, CT 06902
- ○ **Wilton** — 30 Danbury Rd., Wilton, CT 06897

High Field MRI Centers

- ○ **Shelton** — 4 Corporate Dr., Suite 182, Shelton, CT 06484
- ○ **Stratford** — 2876 Main St., Stratford, CT 06614

Patient Name _____

DOB _____ Preferred Phone # _____

Patient Email _____

Appt. Date/Time _____

Insurance _____

ID# _____

Prior Auth Req.? ○ No ○ Yes Auth.# _____

AFTER HRS/STAT CALL BACK # _____

Referring Practitioner (please print)

Name _____

Phone # _____

Electronically Signed By _____

Date _____ CC: _____

CPT Code _____ **HCPCS Mod.** _____

G-Code _____

○ Without Contrast

○ With ***AND*** Without Contrast

Lab Values for Contrast Exams:

☐ eGFR _____

☐ Lab: _____

_____

Date _____

Height _____ Weight _____ Sex: ○ M ○ F ☐ **Claustrophobic**

Implanted Medical Devices (please specify) _____

Manufacturer and Model No. _____

Pertinent History / Special Instructions _____

Signs and Symptoms _____

ICD-10 Codes _____

Of clinical importance:
Rule out / History of / Question of _____

Brain
☐ Brain
☐ Spectroscopy

NeuroQuant:
☐ Brain w/ and w/o
☐ Brain w/o

Head and Neck
☐ Orbits
☐ Soft Tissue Neck/Parotid
☐ Brachial Plexus: ☐ Right ☐ Left
☐ Other: (Please specify)

_____

Spine
☐ Cervical Spine
☐ Thoracic Spine
☐ Lumbar Spine
☐ Total Spine Series
☐ Lumbosacral Plexus

Body
☐ Abdomen: (specify)_____
☐ Abdomen w/MRCP
☐ Chest: (specify)_____
☐ Pelvis: (specify)_____
☐ MRCP
☐ Prostate (3T Preferred)
☐ Enterography: w/ and w/o contrast

Breast MRI
☐ Bilateral

MRA Studies
☐ Head: Circle of Willis (High Field Preferred)
☐ MRV Head
☐ Neck: Carotid (w/ and w/o Preferred)
☐ Chest
☐ Renal
☐ Run-Off
☐ Other: (Please specify)

_____

Please Check If Applicable:
☐ Acute Stroke
☐ Cranial Nerve
☐ Seizure
☐ Pituitary
☐ IAC / Post Fossa
☐ NPH / Dementia
☐ MS
☐ Myelopathy
☐ Acute Trauma
☐ Metastasis
☐ Compression Fracture

Musculoskeletal System
☐ **ARTHROGRAM REQUESTED**
☐ Shoulder: ☐ Right ☐ Left
☐ Elbow: ☐ Right ☐ Left
☐ Wrist: ☐ Right ☐ Left
☐ Hand: ☐ Right ☐ Left
☐ Fingers: ☐ Right ☐ Left
☐ Hip: ☐ Right ☐ Left
☐ Knee: ☐ Right ☐ Left
☐ Ankle: (to include hind/mid foot) ☐ Right ☐ Left
☐ Ankle: (to include Achilles) ☐ Right ☐ Left
☐ Foot: (to include metatarsals/toes) ☐ Right ☐ Left
☐ Upper Extremity Other Than Joint: ☐ Right ☐ Left

_____
(Please specify body part)

☐ Lower Extremity Other Than Joint: ☐ Right ☐ Left

_____
(Please specify body part)

☐ Other: (Please specify)

_____