Silicon Valley MRI & CT

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Date: _____

Patient's Name: _____ Date of Birth: _____ Patient's Phone: _____

Clinical Information:

MRI

Head & Neck		*Spine*	*Upper Ext*	*(circle side)*	*Lower Ext*	*(circle side)*	*Other*
☐ Brain	☐ MRA head	☐ Cervical	☐ Shoulder	R or L	☐ Hip	R or L	☐ Abdomen
☐ IAC	☐ MRA neck	☐ Thoracic	☐ Elbow	R or L	☐ Knee	R or L	☐ Pelvis
☐ Pituitary	☐ Soft tissue neck	☐ Lumbar	☐ Wrist	R or L	☐ Ankle/hindfoot	R or L	☐ Sacrum/coccyx
☐ Orbits					☐ Forefoot	R or L	☐ Sacroiliac joints

☐ **Gadolinium** | MR arthrography (specify): | Other (specify):

CT

Head & Neck	*Spine*	*Chest*	*Abdomen/pelvis*
☐ Head WO	☐ Cervical WO	☐ Chest WO	☐ Abdomen/pelvis WO
☐ Sinuses low dose/limited	☐ Thoracic WO	☐ Chest W	☐ Abdomen/pelvis W
☐ Sinuses complete	☐ Lumbar WO	☐ Chest PE protocol	☐ Abdomen/pelvis WOW
☐ Sinuses Landmarx		☐ HRCT (interstitial disease)	☐ Pelvis WO
☐ Neck WO	☐ Cervical myelogram	Other (specify):	
☐ Neck W	☐ Thoracic myelogram		
☐ Temporal bones WO	☐ Lumbar myelogram		

CTA (specify): | CT arthrography (specify): | CT extremity (specify):

US

☐ Liver/gallbladder	☐ Renal (includes bladder)	☐ Female pelvis	☐ DVT lower extremity R or L
☐ Abdomen complete	☐ Bladder only	☐ Thyroid	Other (specify):
☐ Aorta/IVC	☐ Scrotum	☐ Carotid	

X-Ray

☐ Chest	☐ Cervical spine	☐ Shoulder R or L	☐ Hip R or L
☐ Paranasal sinuses	☐ Thoracic spine	☐ Elbow R or L	☐ Knee R or L
☐ Abdomen (KUB)	☐ Lumbar spine	☐ Wrist R or L	☐ Ankle R or L
☐ Pelvis	☐ Scoliosis study	☐ Hand R or L	☐ Foot R or L

Other exam (specify):

For contrast studies (age ≥65 or renal disease): eGFR _____ Creatinine _____ Date _____

☐ ***Radiologist may revise order as clinically indicated.*** ☐ **STAT**

I certify that these services are medically necessary.

Physician's Signature: _____ Physician's Phone: _____

Physician's Name (print): _____ Physician's Fax: _____