McLaren GREATER LANSING

MR Referral Form

MSU Health Care at McLaren GREATER LANSING

3220 Discovery Dr, Suite 100
Lansing, MI 48910-8556
Ph 517-975-8930 • Fax 517-337-4985
Tax ID 38-1434090 • NPI 1134104672

Patient Name _____ DOB _____ Phone _____

Diagnosis/ICD Code(s)/Signs & Symptoms _____

Injury Date _____ ☐ Male ☐ Female Weight _____

Insurance Type(s) _____ Preauthorization # _____

MRI

Head MRI

- ☐ Brain
- ☐ Iac (Internal Auditory Canals)
- ☐ Orbits
- ☐ Pituitary
- ☐ TMJ (Temporo-Mandibular Joint)

Spine MRI

- ☐ Cervical
- ☐ Thoracic
- ☐ Spinal Cord _____
- ☐ Lumbar (LS/Lumbo Sacral)
- ☐ Sacrum
- ☐ Sacroiliac (S.I.) Joint

Upper Extremities & Joints MRI

- ☐ L ☐ R Shoulder
- ☐ L ☐ R Scapula
- ☐ L ☐ R Upper Arm (Humerus)
- ☐ L ☐ R Elbow
- ☐ L ☐ R Lower Arm (Radius/Ulna)
- ☐ L ☐ R Wrist
- ☐ L ☐ R Hand

Lower Extremities & Joints MRI

- ☐ L ☐ R Hip
- ☐ L ☐ R Upper Leg (Femur)
- ☐ L ☐ R Knee
- ☐ L ☐ R Lower Leg (Tibia/Fibula)
- ☐ L ☐ R Ankle (Includes Achilles)
- ☐ L ☐ R Foot

MR ANGIOGRAPHY (MRA)

- ☐ Head Angiography (Cerebral)
- ☐ Neck Angiography (Carotid & Vertebral)
- ☐ Upper Extremity Angiography
- ☐ Chest Angiography
- ☐ Spinal Canal Angiography
- ☐ Abdomen/Renal Angiography
- ☐ Pelvis Angiography
- ☐ Lower Extremity Angiography

MRI/ARTHROGRAMS

- ☐ L ☐ R MRI/Arthrogram Shoulder
- ☐ L ☐ R MRI/Arthrogram Elbow
- ☐ L ☐ R MRI/Arthrogram Wrist
- ☐ L ☐ R MRI/Arthrogram Hip
- ☐ L ☐ R MRI/Arthrogram Knee
- ☐ L ☐ R MRI/Arthrogram Ankle

MISCELLANEOUS MR

- ☐ Neck (Soft Tissue)
- ☐ L ☐ R Brachial Plexus
- ☐ Chest
- ☐ Breast MRI (Bilateral)
  Attn: ○ Lt ○ Rt
- ☐ Abdomen (NPO 4 hours)
- ☐ Pelvis (NPO 4 hours)
  ○ Sports Hernia
- ☐ Spectroscopy (Also select anatomy)
- ☐ Magnetic Resonance Venogram (MRV)
- ☐ Other _____

MR PRE-SCREENING

Please answer the following questions to assist with scheduling.

Pacemaker	☐ YES	☐ NO
Aneurysm Clip	☐ YES	☐ NO
Metal (e.g. metal in eyes, surgical implants, etc.)	☐ YES	☐ NO
Stent(s)	☐ YES	☐ NO
Prior surgery to the area being scanned	☐ YES	☐ NO
Pregnant	☐ YES	☐ NO

MR exams with and/or without contrast will be performed per Radiologist's protocol/standard of care.
If you would NOT like contrast administered, check this box: ☐

Referring Physician/Provider Information

Signature or stamp X _____

Physician/Provider Printed Name _____

Form filled out by _____

Office Phone _____ Office Fax _____