



Physician Written Order Form

Baystate MRI & Imaging Center

80 Wason Avenue
Springfield, MA 01107
Phone: 413-730-9200
Fax: 413-732-4771
Tax ID#: 04-3454301
1.5T High Field Open
3T High Field Open

Baystate Franklin MRI

164 High Street
Greenfield, MA 01301
Phone: 413-772-1900
Fax: 413-772-2002
Tax ID#: 16-1766731
1.5T High Field Open

Baystate Mary Lane MRI

85 South Street
Ware, MA 01082
Phone: 413-730-9200
Fax: 413-732-4771
Tax ID#: 04-3454301
1.5T High Field

Note: High Field Open machines accommodate patients up to 550 lbs.

Patient Name: _____ DOB: _____ SS#: _____

Phone: _____ Work / Cell: _____ Email: _____

Physician Name: _____ Phone: _____

Physician Signature: _____

CC: Patient Report to: _____ Fax #: _____

Appt. Date & Time

Billing Information:

Private Health Auto W/C Other Insurance Co. _____

Subscriber ID: _____ Authorization: _____ Valid Dates: _____

Request

Routine Stat

This order includes authorization to perform/obtain an orbital x-ray exam, if necessary based on patient history.

✦ **MRI contrast scans require Creatinine levels for all patients 70+ years, for women 60+ and for all diabetic and renal patients** ✦

Contrast, please check: Without Contrast With Contrast Contrast @ Radiologist Discretion

Requested MRI / MRA Procedures

✦ *Contrast Scan Request Require Lab Values*

- | | | |
|---|--|---|
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Coccyx | <input type="checkbox"/> Orbits |
| <input type="checkbox"/> Abdomen MRA | <input type="checkbox"/> Foot ___Rt. ___Lt. | <input type="checkbox"/> Pelvis |
| <input type="checkbox"/> Ankle | <input type="checkbox"/> Forearm ___Rt. ___Lt. | <input type="checkbox"/> Pelvis MRA |
| <input type="checkbox"/> Brachial Plexus | <input type="checkbox"/> Hand ___Rt. ___Lt. | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Hip ___Rt. ___Lt. | <input type="checkbox"/> Shoulder ___Rt. ___Lt. |
| <input type="checkbox"/> Brain MRA | <input type="checkbox"/> Humerus ___Rt. ___Lt. | <input type="checkbox"/> Soft Tissue Neck |
| <input type="checkbox"/> Brain & Neck MRA | <input type="checkbox"/> Knee ___Rt. ___Lt. | <input type="checkbox"/> Thigh ___Rt. ___Lt. |
| <input type="checkbox"/> Cervical | <input type="checkbox"/> Lower Leg ___Rt. ___Lt. | <input type="checkbox"/> Thoracic |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Lumbar | <input type="checkbox"/> Wrist ___Rt. ___Lt. |
| <input type="checkbox"/> Chest MRA | <input type="checkbox"/> Neck MRA | |

Lab Date: _____

Creatinine: _____

GFR: _____

Other Scan Type: _____

Diagnosis & Symptoms: _____

ICD9 Codes: _____, _____, _____, _____
(see reverse for ICD9 reference guide)