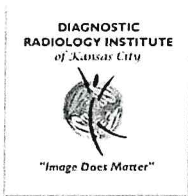

*ALL EXAMS REQUIRE AN APPOINTMENT!

DIAGNOSTIC RADIOLOGY INSTITUTE

"IMAGE DOES MATTER"

6444 Metcalf – Overland Park, KS 66202 * 913-831-0509 * Fax: 913-831-0439

Patient Name: ____________________ DOB: ____________

Patient Phone Number: ____________ Cell: ____________ Work: ____________

Ordering Physician: ____________ (Print Full Name) Phone #: ____________ (Physician Office) Fax # ____________ (Physician Office)

Diagnosis / Reason for Exam: ____________________

Patient's Weight: ____________ INSURANCE ____________________

Physician Signature: ____________________

MRI	MRI (CONTINUED)	X-RAY
CONTRAST:	☐ MR THUMB R L / FINGER R L	☐ ORBITS
☐ WITHOUT	☐ MR HUMERUS R L	☐ CHEST 2 VIEW
☐ WITH / WITHOUT	☐ MR FOREARM R L	☐ RIBS ANT / POST R L
	☐ MR ANKLE R L	☐ NASAL BONE
☐ MR BRAIN	☐ MR FOOT R L	☐ PELVIS
☐ MR IAC	☐ MR OTHER ____________	☐ HIP R L
☐ MR PITUITARY	☐ MRA HEAD (NO CONTRAST)	☐ SKULL
☐ MR ORBIT	☐ MRA NECK (NO CONTRAST)	☐ CERVICAL SPINE ____ VIEWS*
☐ MR BRACHIAL PLEXUS R L	☐ MRV HEAD (NO CONTRAST)	☐ THORACIC SPINE 2 VIEWS
☐ MR SCAPULA R L		☐ LUMBAR SPINE 2 VIEWS
☐ MR CLAVICLE R L		☐ LUMBAR SPINE ____ VIEWS*
☐ MR STERNUM	**TOMOSYNTHESIS**	☐ FEMUR R L
☐ MR PECTORAL MUSCLE R L	☐ LOWER EXTREMITY R L	☐ KNEE R L
☐ MR CERVICAL SPINE	☐ DESCRIPTION: ____________	☐ TIB / FIB R L
☐ MR THORACIC SPINE	☐ ____________	☐ ANKLE R L
☐ MR LUMBAR SPINE	☐ DESCRIPTION: ____________	☐ FOOT R L
☐ MR PELVIS	☐ ____________	☐ HAND R L
☐ MR SACRUM	☐ UPPER EXTREMITY R L	☐ FINGERS / THUMB R L
☐ MR SOFT TISSUE NECK	☐ DESCRIPTION: ____________	☐ WRIST R L
☐ MR KNEE R L	☐ ____________	☐ FOREARM R L
☐ MR HIP R L	☐ LONG BONE	☐ ELBOW R L
☐ MR SHOULDER R L	☐ DESCRIPTION: ____________	☐ HUMERUS R L
☐ MR ELBOW R L	☐ ____________	☐ CLAVICLE R L
☐ MR WRIST R L	☐ CERVICAL SPINE	☐ SHOULDER R L
☐ MR HAND R L	☐ THORACIC SPINE	☐ KUB
☐ MR FEMUR R L	☐ LUMBAR SPINE	☐ OTHER: ____________
☐ MR TIB / FIB R L	☐	☐

R = RIGHT SIDE L = LEFT SIDE *PLEASE CIRCLE IF OBLIQUE AND / OR FLEXION / EXTENSION