

McLaren Print System Order

Order No: 77241
 Order Date: 2023-05-12
 User: Deb House
 Phone: 989-269-9521

Ship Location: McLaren Thumb Attn Deb House, Imaging
 1100 S VAN DYKE RD
 BAD AXE, MI 48413

Forms

Quantity: 500
 Paragon Dept No: 27250
 Dept Name: Medical Imaging
 Company Number: 530

Order Total Price: 0.00

Item Number: MTR-14
 Item Description: MRI Order Form
 Revision Date: 05/2023
 Print: 2 sided black and white
 Paper: 20# White Text
 Size: 8.5 x 11
 Fold:
 Finish: None
 Drill: None
 Poster:
 Misc Info:

1100 S. Van Dyke, Bad Axe, MI 48413
(989) 269-1565

Patient Name _____
 Patient DOB _____
 Ordering Physician _____
 Ordering Signature _____
 Phone _____
 Fax Report To _____
 Supervising Physician _____

Description	Without Contrast	Without & With Contrast
MRI Head/Neck		
MRI Brain		
MRI IAC		
MRI Pituitary		
MRI Chiasm		
MRI Acq/Pituitary		
MRI Neck (Soft Tissue)		
MRI Neck <input type="checkbox"/> RT <input type="checkbox"/> LT		
MRI Spine		
MRI Cervical Spine		
MRI Thoracic Spine		
MRI Lumbar Spine		
MRI Sacrum/Coccyx		
MRI Sacro-Coc Coccyx		
MRI Body/Extrem		
MRI Extremity <input type="checkbox"/> Without Contrast <input type="checkbox"/> With Contrast		
MRI Hip <input type="checkbox"/> Anterior <input type="checkbox"/> Posterior		
MRI Pelvis <input type="checkbox"/> Bony <input type="checkbox"/> Nonbony <input type="checkbox"/> Soft Tissue		
MRI Chest		
MRI Breast/Pituitary <input type="checkbox"/> RT <input type="checkbox"/> LT		
MRI Angiogram		
MRI Brain (Code of MRI)		
MRI Brain (Digital Sub)		
MRI Neck Carotids		
MRI Arteries <input type="checkbox"/> Aorta <input type="checkbox"/> Renal Artery		
MRI Chest Aorta		
MRI Lower Extremity Run off		

Authorization # _____
(Required)

Appt Date _____ Time _____

Patient Weight _____

Clinical Signs/Symptoms (REQUIRED)

Description	Without Contrast	Without & With Contrast
MRI Extremity/Neck		
MRI Shoulder <input type="checkbox"/> RT <input type="checkbox"/> LT		
MRI Scapula <input type="checkbox"/> RT <input type="checkbox"/> LT		
MRI H-Neck <input type="checkbox"/> RT <input type="checkbox"/> LT		
MRI Wrist <input type="checkbox"/> RT <input type="checkbox"/> LT		
MRI Hand <input type="checkbox"/> RT <input type="checkbox"/> LT		
MRI Upper Arm/Humeral Head <input type="checkbox"/> RT <input type="checkbox"/> LT		
MRI Forearm/Elbow/Wrist <input type="checkbox"/> RT <input type="checkbox"/> LT		
MRI Ankle/Heel <input type="checkbox"/> RT <input type="checkbox"/> LT		
MRI Lower Leg <input type="checkbox"/> RT <input type="checkbox"/> LT		
MRI Hip <input type="checkbox"/> RT <input type="checkbox"/> LT		
MRI Knee <input type="checkbox"/> RT <input type="checkbox"/> LT		
MRI Ankle <input type="checkbox"/> RT <input type="checkbox"/> LT		
MRI Foot <input type="checkbox"/> RT <input type="checkbox"/> LT		
<input type="checkbox"/> Fore Foot (heel to ankle) <input type="checkbox"/> Mid Foot (metatarsals to ankle) <input type="checkbox"/> Hind Foot (heel to metatarsals) <input type="checkbox"/> Entire Foot (heel to distal toe)		
Other		

If Authorization **HAS** been obtained, please call (989) 269-1565 to schedule an appointment.

If Authorization **HAS NOT** been obtained, please FAX a **SIGNED** copy of this request to (734) 255-4343.

Spec Info: