

McLaren Print System Order

Order No: 77752
Order Date: 2023-06-12
User: Amber Kleekamp
Phone: 9895519951

Ship Location: McLaren Medical Group
1054 S. Van Dyke RD
Bad Axe, MI 48413

Forms

Quantity: 100
Paragon Dept No: 26800
Dept Name: McLaren Medical Group
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:



THUMB REGION

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

Patient Name _____

Patient DOB _____

Ordering Physician _____

Ordering Signature _____
Required

Phone _____

Fax Report To _____

Supervising Physician _____

Description	Without Contrast	Without & With Contrast
MRI Head/Neck		
MRI Brain		
MRI IAC		
MRI Pituitary		
MRI Orbits		
MRI Face/Parotid		
MRI Neck (Soft Tissue)		
MRI TMJ <input type="checkbox"/> RT <input type="checkbox"/> LT		
MRI Spine		
MRI Cervical Spine		
MRI Thoracic Spine		
MRI Lumbar Spine		
MRI Sacrum/Coccyx		
MRI Sacro-Iliac Joints		
MRI Body/Chest		
MRI Abdomen <input type="checkbox"/> Liver <input type="checkbox"/> Kidneys <input type="checkbox"/> Adrenals <input type="checkbox"/> Pancreas		
MRCP		
MRI Pelvis <input type="checkbox"/> Bony <input type="checkbox"/> Female <input type="checkbox"/> Soft Tissue		
MRI Chest		
MRI Brachial Plexus <input type="checkbox"/> RT <input type="checkbox"/> LT		
MRA Angiogram		
MRA Brain (Circle of Willis)		
MRV Brain (Sagittal Sinus)		
MRA Neck/Carotids		
MRA Abdomen <input type="checkbox"/> AAA <input type="checkbox"/> Renal Artery		
MRA Chest/Aorta		
MRA Lower Extremity Run off		

Spec Info:

Authorization # _____
(if required)

Appt Date _____ Time _____

Patient Height _____ Patient Weight _____

Clinical Signs/Symptoms (REQUIRED)

Description	Without Contrast	Without & With Contrast
MRI Extremities/Joints		
MRI Shoulder <input type="checkbox"/> RT <input type="checkbox"/> LT		
MRI Scapula <input type="checkbox"/> RT <input type="checkbox"/> LT		
MRI Elbow <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/Humerus Biceps <input type="checkbox"/> RT <input type="checkbox"/> LT		
MRI Forearm/Ulna/Radius <input type="checkbox"/> RT <input type="checkbox"/> LT		
MRI Femur/Thigh <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 (toes to Metatarsals) <input type="checkbox"/> Mid Foot (metatarsals to tarsals) <input type="checkbox"/> Hind Foot (tarsals to calcaneus) <input type="checkbox"/> Entire Foot (toes to calcaneus)		

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) 259-624.