

**McLaren Print System Order**

**Order No:** 81715  
**Order Date:** 2023-12-15  
**User:** Deb House  
**Phone:** 989-269-1557

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

**Forms**

**Quantity:** 100  
**Paragon Dept No:** 27265  
**Dept Name:** MRI  
**Company Number:** 530

**Order Total Price:** 4.48

**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
<b>MRI Head/Neck</b>		
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		
<b>MRI Spine</b>		
MRI Cervical Spine		
MRI Thoracic Spine		
MRI Lumbar Spine		
MRI Sacrum/Coccyx		
MRI Sacro-Iliac Joints		
<b>MRI Body/Chest</b>		
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		
<b>MRA Angiogram</b>		
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
<b>MRI Extremities/Joints</b>		
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.