☐ **CONTRA COSTA IMAGING CENTER**
Tax ID: 68-0202020

☐ **JOHN MUIR MAGNETIC IMAGING CENTER**
Tax ID: 68-0202020

BAY MEDICAL MANAGEMENT, LLC & BAY IMAGING CONSULTANTS MEDICAL GROUP, INC

In partnership with JOHN MUIR HEALTH

MRI REQUISITION

Scheduling Phone: (925) 952-2701 **Scheduling Fax:** (925) 941-4065

Date: _____

Patient Name Last	First	M	DOB

Primary Phone	Name of Insurance
Clinical History / Symptoms	Ins. ID#
	Auth. #
ICD-10 Codes (Required) Diagnosis	Office Contact Person
☐ CDs: ☐ Patient to Hand Carry ☐ Send to Physician	Copies to; Name (Last, First)
Referring Physician (Print Name)	Physician's Signature (Required)

ANESTHESIA REQUIRED? ☐ Yes ☐ No

CLAUSTROPHOBIC? ☐ Yes ☐ No **If medication/sedation is required, please order or provide medication for the patient. The patient is to arrive one hour prior to their exam time with a driver to complete registration and will self-medicate after their interview**

MRI TABLE WEIGHT LIMITS: JMMIC Limit: 550 pounds - CCIC: 550 pounds

Prior related studies ☐ **MRI** ☐ **US** ☐ **CT** ☐ **X-RAY** When: _____ Where: _____

SPECIAL IMAGING INSTRUCTIONS:

IF EXAM NEEDED ON AN EMERGENCY BASIS, PLEASE CALL SCHEDULING (925) 952 - 2701

IMPORTANT: **Please inform us if the patient has had a contrast material reaction; life threatening allergic reaction; organ transplant; diabetes; multiple myeloma or kidney disease. Female patients of child-bearing age should inform us if they are, or might be pregnant. Please note if patient has had Barium Enema or Upper GI within the past week.**

MRI HEAD

- ☐ Brain
- ☐ IACs
- ☐ Orbits
- ☐ Pituitary/Sella
- ☐ Other
- ☐ Stroke Protocol (MRI Brain, MRA Head & Neck)
- ☐ MRA Head (Circle of Willis)
- ☐ MRV Brain

SPINE

- ☐ Thoracolumbar T10-L3
- ☐ Lumbar L1-S1
- ☐ Lumbosacral Plexus Neurogram & Pelvis
- ☐ C-Spine
- ☐ T-Spine
- ☐ Sacrum
- ☐ MRA Neck (carotids/vertebrals)
- ☐ Other _____

MRI BODY

Abdomen (wo/w contrast unless w/o specified)
- ☐ Routine Liver
- ☐ Pancreas with MRCP
- ☐ MRCP (w/o contrast)
- ☐ Renal Mass
- ☐ Adrenal
- ☐ Eovist Liver
- ☐ MRA Abdominal Aorta (including mesenteric arteries)
- ☐ MRA Thoracic Aorta
- ☐ MRA Renal Artery (hypertension)

Pelvis
- ☐ Routine
- ☐ Female Pelvis
- ☐ Endometrial Cancer Staging
- ☐ Rectal CA Protocol
- ☐ Prostate
- ☐ Anal Fistula
- ☐ Scrotum/Penis
- ☐ Other _____

Abdomen/Pelvis
- ☐ Routine
- ☐ Enterography
- ☐ Urography
- ☐ Other _____

Chest/Neck
- ☐ Neck (soft tissue)
- ☐ Brachial Plexus
- ☐ Breast(s)
- ☐ Chest/Mediastinum
- ☐ MRV of Body Part: _____
- ☐ Other _____

The Radiologist will determine the parameters of the diagnostic test based on patient symptoms and protocols unless the ordering physician has marked this box: [ ] Do not make changes to this order.

EXTREMITY

Arthrogram Injection
☐ YES ☐ NO

☐ Shoulder	☐ L	☐ R
☐ Elbow	☐ L	☐ R
☐ Wrist	☐ L	☐ R
☐ Knee	☐ L	☐ R
☐ Hip	☐ L	☐ R

☐ Hand	☐ L	☐ R
☐ Ankle (Hindfoot & Midfoot)	☐ L	☐ R
☐ Forefoot/Toes	☐ L	☐ R
☐ Whole foot (to r/o osteomyelitis only)	☐ L	☐ R
☐ MRA Peripheral Artery Runoff (includes MRA lower extremity, abdomen, pelvis)	☐ L	☐ R

☐ Other ☐ L ☐ R _____