



9758 East 21st Street
 North Suite 300 Wichita,
 KS 67206
www.elitedximagining.com

Appt. Date: _____
 Appt. Time: _____

Scheduled by: _____ Date: _____

Patient: _____ DOB _____

Home Phone _____ Work Phone _____

Reason for Exam _____

Ordering DR./RNP/PA _____ CD: (Yes) (No)

Ordering Clinic _____ Phone _____ Fax _____

Physician Signature: _____ Insurance Company Benefit Phone # _____ Insurance: _____
 _____ Policy Holder ID: _____

Precert needed: (Yes) (No) Precert# _____ SS# _____

Work Injury? _____ Auto Accident? _____ Illness? _____

Date of Injury/Accident or Illness? _____ Claim # _____

1.2T High Field Open Magnet 3.0T Closed Magnet

MRI		
<input type="checkbox"/> Head	<input type="checkbox"/> W/O	<input type="checkbox"/> W, W/O
<input type="checkbox"/> IAC's	<input type="checkbox"/> W/O	<input type="checkbox"/> W, W/O
<input type="checkbox"/> Pituitary	<input type="checkbox"/> W/O	<input type="checkbox"/> W, W/O
<input type="checkbox"/> Orbits	<input type="checkbox"/> W/O	<input type="checkbox"/> W, W/O
<input type="checkbox"/> Soft Neck Tissue	<input type="checkbox"/> W/O	<input type="checkbox"/> W, W/O
<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> W/O	<input type="checkbox"/> W, W/O
<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/> W/O	<input type="checkbox"/> W, W/O
<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> W/O	<input type="checkbox"/> W, W/O
<input type="checkbox"/> Sacrum	<input type="checkbox"/> W/O	<input type="checkbox"/> W, W/O
<input type="checkbox"/> Pelvis	<input type="checkbox"/> W/O	<input type="checkbox"/> W, W/O
<input type="checkbox"/> MRCP	<input type="checkbox"/> W/O	<input type="checkbox"/> W, W/O
<input type="checkbox"/> Abdomen	Atten: _____	

MRI	
<input type="checkbox"/> Hip	RT/LT
<input type="checkbox"/> Knee	RT/LT
<input type="checkbox"/> Ankle	RT/LT
<input type="checkbox"/> Shoulder	RT/LT
<input type="checkbox"/> Elbow	RT/LT
<input type="checkbox"/> Wrist	RT/LT
<input type="checkbox"/> Forefoot	RT/LT
<input type="checkbox"/> Midfoot	RT/LT
<input type="checkbox"/> Hindfoot	RT/LT
Procedures:	
<input type="checkbox"/> Arthrograms	_____ RT/LT
<input type="checkbox"/> Pain Injections	_____ RT/LT

Check here if Physician Authorizes screening orbits for metal in the eyes if deemed necessary:

MRI Angiography		
<input type="checkbox"/> MRA Head	<input type="checkbox"/> W/O	<input type="checkbox"/> W, W/O
<input type="checkbox"/> MRA Neck	<input type="checkbox"/> W/O	<input type="checkbox"/> W, W/O
<input type="checkbox"/> MRA Abdomen	<input type="checkbox"/> W/O	<input type="checkbox"/> W, W/O
<input type="checkbox"/> MRA Renal	<input type="checkbox"/> W/O	<input type="checkbox"/> W, W/O

Notes
<input type="checkbox"/> _____

Do you want contrast for your exam? (Yes) (No)
 Indication: _____ Pt Hx CA? (Yes) (No)

Screening Questions

- | | | |
|-------|-------|--|
| Yes | No | |
| _____ | _____ | Is the patient Claustrophobic? If YES, have they been prescribed a sedative? (Yes) (No) |
| _____ | _____ | Has the patient ever had a history of metal or metal fragments in their eyes? |
| _____ | _____ | Has the patient ever worked in a job as a sheet metal worker or welder? |
| _____ | _____ | Has the patient ever had any heart, vascular, aneurysm surgery, eye or ear surgery? |
| _____ | _____ | Does the patient have implanted electronic devices? (Pacemaker, Medication Pump, Neuro Stimulator) |
| _____ | _____ | Is there a possibility of pregnancy? |
| _____ | _____ | Any surgery to the area being scanned? If Yes what type? _____ |

***** Previous imaging studies and reports are helpful at the time of study.**

Important Information Regarding Your Examination at Elite Diagnostic

- ☺ Please alert us at time of scheduling if you have a pacemaker, any implants, implanted pumps, vena cava filters, or metal in the eyes.
- ☺ If you are having an MRI of the Abdomen or Pelvis please do not eat or drink anything for 4 hours prior to your appointment time.
- ☺ Please leave all jewelry and valuables at home. If you have body piercings please remove them prior to appointment.
- ☺ If you are able to wear clothing with no metal on it your exam will be more comfortable. You can even bring a change of comfortable clothing to the exam. (ie: Sweat pants, tee shirts, sports bras)
- ☺ If there is any possibility that you might be pregnant, please let our office know at the time of scheduling.
- ☺ If you have any questions regarding your examination, please be sure to contact our office, and we will be glad to help you.

