



Place Patient Label  
Inside This Box

**Physicians Order for  
MRI – Lee Campus**  
Page 1 of 1

Name:	Sex:	Date of Birth:	Age:	SS#:
Telephone:(Home)	(Work)	(Mobile)	PreCert/Auth#:	
Provider Ph#	Provider Fax#:	Print Name of Provider:		

**Provider Signature (Required)** \_\_\_\_\_ **Date/Time (Required):** \_\_\_\_\_

APPOINTMENT REQUESTED THROUGH SCHEDULING SYSTEM

Is patient claustrophobic or over 300lbs?  Yes  No Does patient have an aneurysm clip or pacemaker?  Yes  No

**CHECK PROCEDURE AND INSERT ICD-10 CODE** CNR = CONTRAST

MRI Stealth / SRS			CPT	DX CODE	MRI EXTREMITIES (CON'T)			CPT	DX CODE
<input type="checkbox"/>	BRAIN W CNTR (Mass/Tumor)		70552		<input type="checkbox"/>	LWR EXT JOINT NO CNTR Ankle, Knee	<input type="checkbox"/> L <input type="checkbox"/> R	73721	
<input type="checkbox"/>	BRAIN WO CNTR (Hemorrhage)		70551		<input type="checkbox"/>	LWR EXT JOINT NO CNTR BILATERAL		7372150	
MRI			CPT	DX CODE	MR ANGIOGRAPHY (MRA)			CPT	DX CODE
<input type="checkbox"/>	BRAIN NO CNTR (MS, CVA, Seizure, HA, ICH)		70551		<input type="checkbox"/>	LWR EXT JNT WO/W CNTR (Abscess/Tumor)	<input type="checkbox"/> L <input type="checkbox"/> R	73723	
<input type="checkbox"/>	BRAIN W/WO CNTR (Reason for exam)		70553		<input type="checkbox"/>	LWR EXT JNT WO/W CNTR BILATERAL		7372350	
	<input type="checkbox"/> Sella/Pituitary <input type="checkbox"/> IAC's <input type="checkbox"/> METS <input type="checkbox"/> Orbits <input type="checkbox"/> Tumor <input type="checkbox"/> MS				<input type="checkbox"/>	LWR EXT NON JNT NO CNTR (Femur/Leg)	<input type="checkbox"/> L <input type="checkbox"/> R	73718	
	<input type="checkbox"/> Cranial Nerves (SPECIFY):				<input type="checkbox"/>	LWR EXT NON JNT WO/W CNTR (Abscess/Tumor)	<input type="checkbox"/> L <input type="checkbox"/> R	73720	
<input type="checkbox"/>	NECK/NASOPHARYNX W/WO CNTR		70543		<input type="checkbox"/>	LWR EXT NON JNT WO/W CNTR BILATERAL		7372050	
<input type="checkbox"/>	TMJ		70336		<input type="checkbox"/>	FOOT No CNTR - ( <input type="checkbox"/> Heel to Mid) ( <input type="checkbox"/> Mid to Toe)	<input type="checkbox"/> L <input type="checkbox"/> R	73718	
<input type="checkbox"/>	CHEST NO CNTR		71550		<input type="checkbox"/>	FOOT WO/W CNTR - ( <input type="checkbox"/> Heel to Mid) ( <input type="checkbox"/> Mid to Toe)	<input type="checkbox"/> L <input type="checkbox"/> R	73720	
<input type="checkbox"/>	CHEST W/WO		71552						
<input type="checkbox"/>	ABDOMEN NO CNTR		74181		<input type="checkbox"/>	BRAIN/HEAD NO CNTR	<input type="checkbox"/> MRA <input type="checkbox"/> MRV	70544	
<input type="checkbox"/>	ABDOMEN WO/W CNTR (Reason for exam)		74183		<input type="checkbox"/>	NECK W/WO CNTR		70549	
	<input type="checkbox"/> Liver <input type="checkbox"/> Spleen <input type="checkbox"/> Pancreas <input type="checkbox"/> Kidneys <input type="checkbox"/> Adrenals				<input type="checkbox"/>	NECK WO CNTR		70547	
<input type="checkbox"/>	MRCP-ABDOMEN NO CNTR		74181		<input type="checkbox"/>	UPPER EXT W/WO CNTR	<input type="checkbox"/> L <input type="checkbox"/> R	73225	
<input type="checkbox"/>	PELVIS/HIP NO CNTR		72195		<input type="checkbox"/>	PELVIS W/WO CNTR	<input type="checkbox"/> MRA <input type="checkbox"/> MRV	72198	
<input type="checkbox"/>	PELVIS/HIP WO/W CNTR (If organ specify, reason)		72197		<input type="checkbox"/>	CHEST W/WO CNTR		71555	
	<input type="checkbox"/> Mass <input type="checkbox"/> Prostate <input type="checkbox"/> Female Organs <input type="checkbox"/> Infection <input type="checkbox"/> Rectum <input type="checkbox"/> Bony								
<input type="checkbox"/>	MR-PROSTATE W / WO		72197						
<input type="checkbox"/>	CERVICAL SPINE NO CNTR (HNP, TRAUMA)		72141						
<input type="checkbox"/>	THORACIC SPINE NO CNTR (HNP, STENOSIS)		72146						
<input type="checkbox"/>	LUMBAR SPINE NO CNTR (HNP, STENOSIS)		72148						
<input type="checkbox"/>	CERVICAL W/WO (POST-OP, TUMOR, METS, INFECTION)		72156						
<input type="checkbox"/>	THORACIC W/WO CNTR (METS, INFECTION)		72157						
<input type="checkbox"/>	LUMBAR W/WO CNTR (Post-OP,METS, Infection)		72158						
MRI EXTREMITIES			CPT	DX CODE	<input type="checkbox"/> <b>RUN-OFF: (includes both when checked)</b> ABDOMEN W/WO CNTR 74185 BILATERAL LWR EXT W CNTR 73725 ABDOMEN W/WO CNTR 74185 <input type="checkbox"/> AAA <input type="checkbox"/> RENAL <input type="checkbox"/> MESENTERIC ARTERIES ABDOMEN WO CNTR (RENAL) C8901				
<input type="checkbox"/>	UPPER EXT JOINT NO CNTR (Wrist Elbow or Shoulder)	<input type="checkbox"/> L <input type="checkbox"/> R	73221						
<input type="checkbox"/>	UPPER EXT JOINT NO CNTR BILATERAL		7322150						
<input type="checkbox"/>	UPPER EXT JOINT WO/W CNTR	<input type="checkbox"/> L <input type="checkbox"/> R	73223						
<input type="checkbox"/>	UPPER EXT JOINT WO/W CNTR BILATERAL		7322350						
<input type="checkbox"/>	UPPER EXT NON-JOINT NO CNTR (Forearm, Hand, Humerus)	<input type="checkbox"/> L <input type="checkbox"/> R	73218						
<input type="checkbox"/>	UPPER EXT NON JNT WO/W CNTR	<input type="checkbox"/> L <input type="checkbox"/> R	73220						
<input type="checkbox"/>	UPPER EXT NON-JOINT WO/W CNTR BILTRL		7322050						

Call Results to: \_\_\_\_\_ After Hours#: \_\_\_\_\_

**Creatinine within the last 30 Days:**

Yes, Results: \_\_\_\_\_, also fax to (910)715-1177

No, Refer to policy on back of form

Place **Creatinine** order

**If patient requires additional imaging for metal objects prior to MRI, I agree to additional images. Use DX: Z01.89 Encounter for Imaging to screen for metal prior to MRI for additional imaging.**

**Comments:**

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Appointment Date/Time:	<input type="checkbox"/>	Spoke to patient	<input type="checkbox"/>	Left message for patient	<input type="checkbox"/>	No answer
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Physicians Order for  
MRI – Lee Campus

<b>**Special Instructions to Ordering Provider:</b>	<b>**Special Instructions to Patient:</b>
<input type="checkbox"/> <b>MR Lower/Upper Extremity (NON-JOINT)</b> Please fax an H&P to 715-1177	<input type="checkbox"/> If you have a pacemaker or aneurysm clip please notify the technologist, you may not be able to have an MRI
<input type="checkbox"/> All MR procedures ordered <b>with contrast</b> must have a <b>Creatinine</b> within the last 30 days if they meet any of the following criteria: 1. history of renal disease, diabetes, hypertension, liver transplant, or severe hepatic disease 2. over the age of 60 (Fax results to 715-1177 prior to patient's appointment) <b>Request Creatinine order if needed.</b>	<input type="checkbox"/> Please wear comfortable clothing and refrain from wearing all jewelry or hairpins.  <input type="checkbox"/> Please arrive <b>30 minutes</b> prior to your appointment time to register, unless instructed otherwise.
	<input type="checkbox"/> <b>MRCP</b> - Nothing to eat or drink for 6 hours prior to your appointment.

**IF SCHEDULING VIA FAX, PLEASE INCLUDE THE**

**FOLLOWING INFORMATION:** Day of the week: Preference: Morning Afternoon Evening

**Please fax form to Central Scheduling at (910) 715-1177. Scheduling will contact the patient.**

If you have not been contacted within one business day about your appointment, please call (910) 715-2778 or (866) 415-2778.

Appointment Date/Time:  Spoke to patient  Left message for Patient  No answer

**FirstHealth Lee Medical Office Building Area Map**



**2919 Beechtree Drive, Sanford, NC 27330**

To Access Beechtree Drive from US-1, you must take the 15-501 exit #71 towards Pittsboro.  
Beechtree Drive will be on your left once you go through the traffic circle.