



Place Patient Label  
Inside This Box

**Physicians Order for Diagnostics MRI**  
- Hoke Campus

Name:		Sex:	Date of Birth:		Age
Telephone:(Home)		(Work)	(Mobile)		PreCert/Auth#:
Physician Ph#		Physician Fax#:		Print Name of Physician:	
<b>Physician Signature (Required)</b>			<b>Date/Time (Required):</b>		
<input type="checkbox"/> APPOINTMENT REQUESTED THROUGH SCHEDULING SYSTEM					
<b>IF SCHEDULING VIA FAX, PLEASE INCLUDE THE FOLLOWING INFORMATION:</b>					
Day of the week: _____				Preference: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening	
<b>Please fax form to Central Scheduling at (910) 715-1177. Scheduling will contact the patient.</b>					
Is patient claustrophobic or over 300 lbs? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does patient have an aneurysm clip or pacemaker? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>ATTENTION PATIENT:</b>					
<b>If you have not been contacted within one business day about your appointment, please call (910) 715-2778 or (866) 415-2778.</b>					
<b>CHECK PROCEDURE AND INSERT ICD-10 CODE</b>			<b>CNTR = CONTRAST</b>		

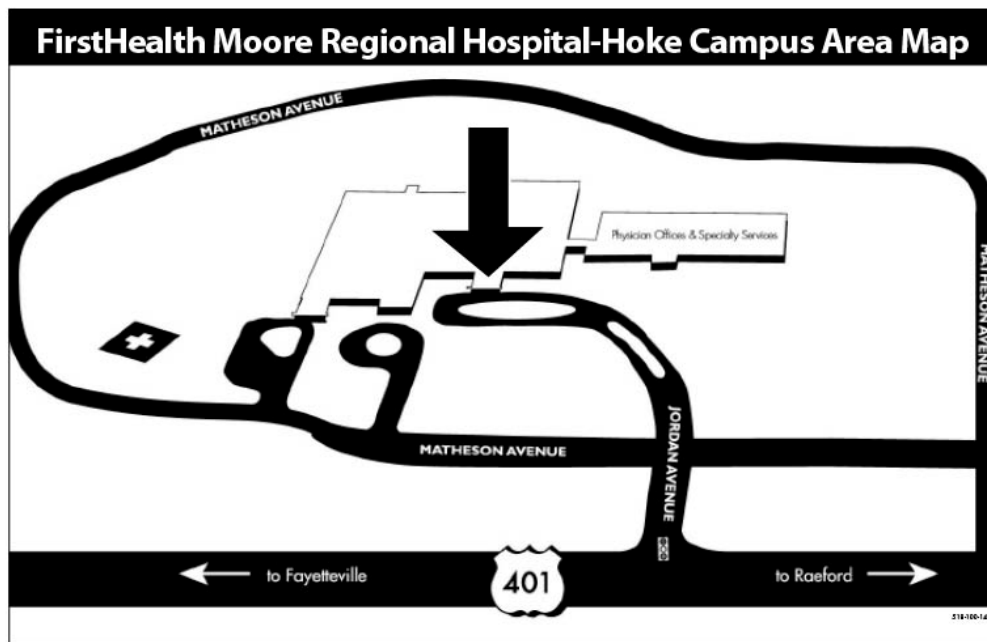
MRI Stealth / SRS	CPT	DX CODE
<input type="checkbox"/> MR-BRAIN W CNTR (Mass/Tumor)	70552	
<input type="checkbox"/> MR-BRAIN WO CNTR (Hemorrhage)	70551	
MRI	CPT	DX CODE
<input type="checkbox"/> MR - BRAIN NO CNTR (MS, CVA, Seizure,HA, ICH)	70551	
<input type="checkbox"/> MR - BRAIN W/WO CNTR (Reason for exam)	70553	
<input type="checkbox"/> MR -NECK/NASOPHARYNX W/WO CNTR	70543	
<input type="checkbox"/> MR - TMJ	70336	
<input type="checkbox"/> MR - CHEST NO CNTR	71550	
<input type="checkbox"/> MR - CHEST W/WO CNTR	71552	
<input type="checkbox"/> MR - ABDOMEN NO CNTR	74181	
<input type="checkbox"/> MR - ABDOMEN W/WO CNTR (Reason for exam)	74183	
<input type="checkbox"/> MRCP - ABDOMEN NO CNTR	74181	
<input type="checkbox"/> MR - PELVIS/Hip NO CNTR	72195	
<input type="checkbox"/> MR - PELVIS W/WO CNTR(If organ specify, reason)	72197	
<input type="checkbox"/> MR - CERVICAL SPINE NO CNTR (HNP, TRAUMA)	72141	
<input type="checkbox"/> MR -THORACIC SPINE NO CNTR(HNP,STENOSIS)	72146	
<input type="checkbox"/> MR - LUMBAR SPINE NO CNTR (HNP,STENOSIS)	72148	
<input type="checkbox"/> MR - CERVICAL W/WO (POST-OP,TUMOR,METS, INFECTION)	72156	
<input type="checkbox"/> MR - THORACIC W/WO CNTR(METS, INFECTION)	72157	
<input type="checkbox"/> MR - LUMBAR W/WO CNTR(Post-OP,METS,Infection)	72158	
MRI EXTREMITIES	CPT	DX CODE
<input type="checkbox"/> MR - UPPER EXT JOINT NO CNTR (Wrist Elbow or Shoulder) <input type="checkbox"/> L <input type="checkbox"/> R	73221	
<input type="checkbox"/> MR - UPPER EXT JOINT NO CNTR BILATERAL	73221-50	
<input type="checkbox"/> MR - UPPER EXT JOINT W/WO CNTR <input type="checkbox"/> L <input type="checkbox"/> R	73223	
<input type="checkbox"/> MR - UPPER EXT JOINT W/WO CNTR BILATERAL	73223-50	
<input type="checkbox"/> MR - UPPER EXT NON JOINT NO CNTR (Forearm, Humerus) <input type="checkbox"/> L <input type="checkbox"/> R	73218	
<input type="checkbox"/> MR - UPPER EXT NON JNT W/WO CNTR <input type="checkbox"/> L <input type="checkbox"/> R	73220	
<input type="checkbox"/> MR - UPPER EXT NON JOINT W/WO CNTR BILTRL	73220-50	

MRI EXTREMITIES (CON'T)	CPT	DX CODE
<input type="checkbox"/> MR - LWR EXT JOINT NO CNTR Ankle, Knee <input type="checkbox"/> L <input type="checkbox"/> R	73721	
<input type="checkbox"/> MR - LWR EXT JOINT NO CNTR BILATERAL	73721-50	
<input type="checkbox"/> MR- LWR EXT JNT W/WO CNTR (Abscess/Tumor) <input type="checkbox"/> L <input type="checkbox"/> R	73723	
<input type="checkbox"/> MR - LWR EXT JNT W/WO CNTR BILATERAL	73723-50	
<input type="checkbox"/> MR - LWR EXT NON JNT NO CNTR (Femur/Lleg) <input type="checkbox"/> L <input type="checkbox"/> R	73718	
<input type="checkbox"/> MR - LWR EXT NON JNT W/WO CNTR (Abscess/Tumor) <input type="checkbox"/> L <input type="checkbox"/> R	73720	
<input type="checkbox"/> MR - LWR EXT NON JNT W/WO CNTR BILATERAL	73720-50	
<input type="checkbox"/> MR - FOOT (Heel To Mid Foot) No CNTR <input type="checkbox"/> L <input type="checkbox"/> R	73721	
<input type="checkbox"/> MR - FOOT W/WO CNTR (Heel to Mid Foot) <input type="checkbox"/> L <input type="checkbox"/> R	73723	
<input type="checkbox"/> MR - FOOT (Mid Foot To Toe) NO CNTR <input type="checkbox"/> L <input type="checkbox"/> R	73718	
<input type="checkbox"/> MR - FOOT W/WO CNTR(Mid Foot to Toe) <input type="checkbox"/> L <input type="checkbox"/> R	73720	
MR ANGIOGRAPHY (MRA)	CPT	DX CODE
<input type="checkbox"/> MRA BRAIN/HEAD NO CNTR <input type="checkbox"/> MRA <input type="checkbox"/> MRV	70544	
<input type="checkbox"/> MRA NECK W/WO CNTR	70549	
<input type="checkbox"/> MRA UPPER EXT W/WO CNTR <input type="checkbox"/> L <input type="checkbox"/> R	73225	
<input type="checkbox"/> MRA PELVIS W/WO CNTR <input type="checkbox"/> MRA <input type="checkbox"/> MRV	72198	
<input type="checkbox"/> MRA CHEST W/WO CNTR	71555	
<input type="checkbox"/> MRA ABDOMEN W/WO CNTR	74185	
<input type="checkbox"/> MRA BILATERAL LWR EXT W CNTR	73725	
<input type="checkbox"/> MRA ABDOMEN W/WO CNTR <input type="checkbox"/> AAA <input type="checkbox"/> RENAL <input type="checkbox"/> MESENTERIC ARTERIES	74185	
After Hours#:		

<b>Comments:</b>				
Appointment Date/Time:		<input type="checkbox"/> Spoke to patient	<input type="checkbox"/> Left message for Patient	<input type="checkbox"/> No answer

## MRI Preps

<input type="checkbox"/> <b>MRCP</b> - Nothing to eat or drink for 6 hours prior to your appointment.	<input type="checkbox"/> <b>If you have a pacemaker or aneurysm clip please notify the technologist, you may not be able to have an MRI</b>
<input type="checkbox"/> <b>MR Lower/Upper Extremity (NON JOINT)-</b> Please fax an H&P to (910)878-6635	<input type="checkbox"/> Please wear comfortable clothing and refrain from wearing jewelry or hairpins
<p><b><u>Special Instructions to Ordering Physician:</u> **</b></p> <input type="checkbox"/> <b>All MR procedures ordered with contrast must have a Creatinine within the <u>last 30 days</u> if they meet any of the following criteria:</b> (Fax results to (910)878-6635 prior to patient's appointment) <ol style="list-style-type: none"> <li>1. history of renal disease, diabetes, hypertension, liver transplant, or severe hepatic disease</li> <li>2. over the age of 60</li> </ol>	<input type="checkbox"/> <b>Please arrive 15 minutes prior to your appointment time to register</b>



**PARKING:** Please check designated parking area for patients:

- |   |  |
|---|--|
| <input type="checkbox"/> <b>Monday – Friday 7:30am – 5:00pm</b>                             | <b>Outpatients will enter through the Outpatient entrance.</b> |
| <input type="checkbox"/> <b>Monday – Friday before 7:30am and after 5:00pm and Weekends</b> | <b>Outpatients will enter through the Emergency Department</b> |