# MRI PRESCRIPTION FORM

□ **W/C**

Insurance Company: _____ Pre-authorization#: _____
Please include driver's license, insurance card(s), and any pre-authorization attained.

Orbit X-rays Location: _____

ORA Imaging Centers - IA
2300 53rd Avenue
Bettendorf, IA 52722
Phone: 563.322.0971
Fax: 563.441.7646

ORA Imaging Centers – IA
6101 Northwest Blvd
Davenport, IA 52806
Phone: 563.322.0971
Fax: 563.441.7646

ORA Imaging Centers - IL
520 Valley View Drive
Moline, Il 61265
Phone: 309.762.3621
Fax: 309.757.8845

Patient's Name: _____

DOB: _____ Phone # _____ Alternative Phone # _____

MRI exam(s): _____

Diagnosis or Symptoms with ICD-10 Code: _____

_____

***MRI Appt Date & Time:*** _____

***Ordering Physician:*** _____
*(Physician Signature)*

***Ordering Physician:*** _____ NPI#: _____
*(Physician Printed)* Physician's Phone #: _____
Physician's Fax #: _____

***Basic MRI Screening:***

| Yes | No | |
|---|---|---|
| □ | □ | Any metal work (grinding, drilling, welding) If YES, orbits ordered at _____ |
| □ | □ | Any metal fragments in your eyes EVER? If YES, orbits ordered at _____ |
| □ | □ | Cardiac pacemaker |
| □ | □ | Cerebral aneurysm clips |
| □ | □ | Is patient claustrophobic, restless, or in a lot of pain? If YES, order medication. |
| □ | □ | History of back or neck surgery? |

***If IV Contrast Used (For mass, infection or history of spine surgery):***
If YES, patient must be sent for labs for GFR to be calculated. Please fax results to ORA Imaging Centers.

| Yes | No | |
|---|---|---|
| □ | □ | Pt over 70 |
| □ | □ | Diabetic |
| □ | □ | Renal Disease |

Labs ordered at: _____