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: _____