



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: 563.441.7608
Fax: 563.441.7646

ORA Imaging Centers - IA
6101 Northwest Blvd
Davenport, IA 52806
Phone: 563.441.7608
Fax: 563.441.7646

ORA Imaging Centers - IL
520 Valley View Drive
Moline, IL 61265
Phone: 309.757.8844
Fax: 309.757.8845

ORA Imaging Centers - IL
985 Avenue of the Cities
Silvis, IL 61282
Phone: 309.865.2619
Fax: 309.865.2675

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 #: _____

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: _____