Trinity Health
Grand Haven

MRI Order Form

Ph. 616-844-4800
Fax 616-844-4801

Patient Name:	DOB _____/_____/_____

Primary Phone #
Insurance provider / Policy #
Pre Authorization #

Diagnosis and symptoms for each area *(include ICD-10 codes & descriptions)*

A	**Encounter**: ❑ Initial ❑ Subsequent ❑ Sequel
	Condition: ❑ Chronic ❑ Acute
	Injury? ❑ Yes ❑ No If YES, date: ____/____/____
	Location of injury:
	Where did injury occur (home, work, etc.)?
	Type of injury (accidental, intentional, assault, etc.):
	Cause of injury:

Anatomy to be scanned:	
Laterality: ❑ Left ❑ Right Digit: _____	
Contrast: ❑ w/contrast ❑ w/o contrast	
Disease stage: ❑ Mild ❑ Moderate ❑ Severe ❑ Indeterminate	
B	Patient's current weight: (Weight limit of 400 lbs.)
C	Has the patient ever had an eye penetrating injury with metal? ☐ Yes ☐ No

D*	Is the patient claustrophobic? ☐ Yes ☐ No

If yes, physician must write a prescription to be taken prior to procedure.

E	Does patient have an ICD, pacemaker or other implants/implanted devices? ☐ Yes ☐ No

F	Is the patient pregnant or breastfeeding? ☐ Yes ☐ No

G	Prior surgery to area(s) being scanned? ☐ Yes ☐ No
	If yes, surgery date:____/____/____

Type of surgery:

H	Prior history of cancer? ☐ Yes ☐ No
	If yes, diagnosis date:____/____/____
	If yes, has patient received chemo or radiation since the last MRI? ☐ Yes ☐ No

Type of cancer: _____
❑ Primary
❑ Secondary

I	Prior MRI, CT, or x-ray to the area being scanned? ☐ Yes ☐ No Facility Name:_____

******* IMPORTANT*******
Please bring copies of previous imaging studies if performed elsewhere.

J	**For Contrast Studies Only:** ☐ **Yes** ☐ **No** Patient is age 60 or older ☐ **Yes** ☐ **No** Patient has history of renal disease or insufficiency ☐ **Yes** ☐ **No** Patient is diabetic: ❑ **Type 1** ❑ **Type 2** ❑ **Secondary** ☐ **Yes** ☐ **No** Patient is receiving chemotherapy ☒ If any of these criteria are met, please order a GFR & Creatinine test (results must be **≤30 days** prior to the CT exam).

GFR result: _____

Creatinine result: _____

Date of most recent GFR/Creatinine results: _____

K	**Breast MRI Patients ONLY:** Date of Last Menstrual Period (LMP): ____/____/____

Appointment Date:	
Time of Arrival:	
Time of Scan:	

AUC INFORMATION
Vendor Name or G-Code _____
Order ID _____
Appropriateness _____
Modifier_____

_____ **Physician Signature**

_____ **Date and Time**