

☐ SOUTHFIELD CAMPUS

22401 Foster Winter Drive
 Southfield, Michigan 48075
 Phone (248) 423-5160
 Fax (248) 423- 5165

**DEPARTMENT OF RADIOLOGY****ALL PATIENTS WHO REQUIRE SEDATION MUST HAVE AN****ADULT STAY IN THE BUILDING DURING THE PROCEDURE AND BE ABLE TO DRIVE THE PATIENT HOME.****☐ WARREN CAMPUS**

11012 Thirteen Mile, Ste. 111
 Warren, MI 48093
 Phone (586) 558-8470
 Fax (586) 558-8481

Please Print

Patient Name	Patient Phone	Date of Birth	Requested Appointment Date & Time
Requesting Physician	Physician Phone	Fax	Fax Report <input type="checkbox"/> Yes <input type="checkbox"/> No
Symptoms: <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Weakness <input type="checkbox"/> Loss of Function <input type="checkbox"/> Other: _____			
Clinical Information:			Previous X-rays or MRI: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pt to bring <input type="checkbox"/> Will Send <input type="checkbox"/> At ORH
Physician Signature:	Allergies: <input type="checkbox"/> NA <input type="checkbox"/> Iodine <input type="checkbox"/> Shellfish Other: _____	Precautions: <input type="checkbox"/> NA	

Place an (X) or write in the examination(s) requested**Magnetic Resonance Imaging (MRI) - Procedural Requirements**

Examination: MRI Follow Radiologist's Recommended Protocol Contrast if Necessary (Please note patient allergies)
 Arthrogram Other: _____

Joint Right Left Bilateral Finger Hand Arm Wrist Elbow Shoulder Hip Leg Knee Ankle Foot
 Other: _____ with & without IV contrast without contrast

Extremity Right Left Bilateral Finger Hand Arm Wrist Elbow Shoulder Hip Leg Knee Ankle Foot
 Other: _____ with & without IV contrast without contrast

Cervical Spine Thoracic Spine Lumbar Spine with & without IV contrast without contrast

Chest Abdomen MRCP Pelvis with & without IV contrast without contrast

Brain with & without IV contrast without contrast Check if attention: Int Aud Canals Pituitary Orbits

Soft Tissue Neck with & without IV contrast without contrast

Other: _____ with & without IV contrast without contrast

Radiology Exam (X-ray)

Skull Orbits Paranasal Sinuses Cervical Spine Thoracic Spine Chest Abdomen

Joint Right Left Bilateral Finger Hand Arm Wrist Elbow Shoulder Hip Leg Knee Ankle Foot
 Other: _____

Extremity Right Left Bilateral Finger Hand Arm Wrist Elbow Shoulder Hip Leg Knee Ankle Foot
 Other: _____

Other _____

Additional Information and/or Request:**Patient Instructions**

- All patients must bring their most recent x-rays, ultrasound reports, and/or films that relate to the current problem.
- All tests – Please arrive 30 minutes prior to your scheduled appointment.