



ORTHOPEDIC ASSOCIATES
of Port Huron, P.C.

MRI

Order Form



MRI Ph: (810)966-8523 | Fax: (810)985-3634
940 River Centre Drive, Port Huron, MI 48060

Date: _____

ANATOMY TO SCAN

SPINE		<input type="checkbox"/> W & W/O Contrast <input type="checkbox"/> Without Contrast	
<input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacrum/Coccyx			
PELVIS		<input type="checkbox"/> W & W/O Contrast <input type="checkbox"/> Without Contrast	
<input type="checkbox"/> Boney <input type="checkbox"/> Soft Tissue			
UPPER EXTREMITY		<input type="checkbox"/> W & W/O Contrast <input type="checkbox"/> Without Contrast	
<input type="checkbox"/> Shoulder <input type="checkbox"/> Humerus <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm <input type="checkbox"/> Wrist <input type="checkbox"/> Hand	<input type="checkbox"/> Left <input type="checkbox"/> Left <input type="checkbox"/> Left <input type="checkbox"/> Left <input type="checkbox"/> Left <input type="checkbox"/> Left	<input type="checkbox"/> Right <input type="checkbox"/> Right <input type="checkbox"/> Right <input type="checkbox"/> Right <input type="checkbox"/> Right <input type="checkbox"/> Right	
LOWER EXTREMITY		<input type="checkbox"/> W & W/O Contrast <input type="checkbox"/> Without Contrast	
<input type="checkbox"/> Hip <input type="checkbox"/> Thigh/ Femur <input type="checkbox"/> Knee <input type="checkbox"/> Lower Leg/ Calf <input type="checkbox"/> Ankle/ Hindfoot <input type="checkbox"/> Forefoot/ Toes	<input type="checkbox"/> Left <input type="checkbox"/> Left <input type="checkbox"/> Left <input type="checkbox"/> Left <input type="checkbox"/> Left	<input type="checkbox"/> Right <input type="checkbox"/> Right <input type="checkbox"/> Right <input type="checkbox"/> Right <input type="checkbox"/> Right	
OTHER: _____			

PATIENT INFORMATION

Patient Name:	_____
Sex:	_____
Weight:	_____
Date of Birth:	_____
	Month / Date / Year
Patient Phone:	_____
Patient Address:	_____

REFERRING PHYSICIAN INFORMATION

Name:	_____
Phone Number:	_____
Address:	_____

Fax Number:	_____
Billing Number:	_____

TO BE COMPLETED BY REFERRING PHYSICIAN

Diagnosis:	_____

Clinical Information:	_____

Physician Signature:	_____
	✕

MRI Appointment Date/ Time: _____