



**ORTHOPEDIC
ASSOCIATES**
of Port Huron, P.C.



MRI

Order Form

TO BE COMPLETED BY PHYSICIAN

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

Date: _____

ANATOMY TO SCAN

HEAD

- | | |
|--------------------------------|--|
| ☐ TMJ's | ☐ W & W/O Contrast |
| | ☐ Without Contrast |
| | ☐ Protocol determined
by Radiologist |

SPINE

- ☐ Cervical
☐ Thoracic
☐ Lumbar
☐ Sacrum/Coccyx

PELVIS

- ☐ Boney Pelvis

UPPER EXTREMITY

- ☐ W & W/O Contrast
☐ Without Contrast
☐ Protocol determined
by Radiologist

- | | | |
|-----------------------------------|-------------------------------|--------------------------------|
| ☐ Shoulder | ☐ Left | ☐ Right |
| ☐ Humerus | ☐ Left | ☐ Right |
| ☐ Elbow | ☐ Left | ☐ Right |
| ☐ Forearm | ☐ Left | ☐ Right |
| ☐ Wrist | ☐ Left | ☐ Right |
| ☐ Hand | ☐ Left | ☐ Right |

LOWER EXTREMITY

- ☐ W & W/O Contrast
☐ Without Contrast
☐ Protocol determined
by Radiologist

- | | | |
|--|-------------------------------|--------------------------------|
| ☐ Hip | ☐ Left | ☐ Right |
| ☐ Thigh/ Femur | ☐ Left | ☐ Right |
| ☐ Knee | ☐ Left | ☐ Right |
| ☐ Lower Leg/ Calf | ☐ Left | ☐ Right |
| ☐ Ankle/ Hindfoot | ☐ Left | ☐ Right |
| ☐ Forefoot/ Toes | ☐ Left | ☐ Right |

PATIENT INFORMATION

Patient Name: _____

Sex: _____ Weight: _____

Date of Birth: _____

Month / Day / Year

Patient Phone: _____

Patient Address: _____

REFERRING PHYSICIAN INFORMATION

Name: _____

Phone Number: _____

Address: _____

Fax Number: _____

Billing Number: _____

Diagnosis: _____

Clinical Information: _____

Physician Signature: _____

X

**If you would like to receive images electronically,
please provide physician e-mail:*

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