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

SPINE		❑W & W/O Contrast ❑Without Contrast ❑Protocol determined by Radiologist	
	❑Cervical		
	❑Thoracic		
	❑Lumbar		
	❑Sacrum/Coccyx		
PELVIS		❑W & W/O Contrast ❑Without Contrast ❑Protocol determined by Radiologist	
	❑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

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

X _____

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: _____

Diagnosis:

Clinical Information:

Physcian Signature:

X