MRI / CT

UMI
UNIVERSITY MEDICAL IMAGING
A UNIVERSITY MEDICAL CENTER FACILITY

Date: ______________________

Patient Name: ______________________ DOB: ____________ Phone: ____________

Patient Insurance: ______________________ Policy #: ____________ Group#: ____________

Prior Authorization # (if req'd): ______________________

Clinical Indication/Diagnosis ______________________

Referring Physician's Name ______________________

Referring Physician's Signature ______________________ Date: ____________

1.5T MRI

IV Contrast ☐ if indicated ☐ No

Creatinine level ____________ Date ____________

- ☐ Brain ☐ Orbits & Brain
- ☐ C-Spine
- ☐ T-Spine
- ☐ L-Spine ☐ Patient is post-op
- ☐ Pituitary
- ☐ IAC's
- ☐ Neck (soft tissue)
- ☐ Breast
- ☐ Abdomen
- ☐ Pelvis ☐ Female Pelvis
- ☐ Shoulder L R
- ☐ Elbow L R
- ☐ Wrist L R
- ☐ Hip L R
- ☐ Knee L R
- ☐ Ankle L R
- ☐ Foot L R
- ☐ Other (specify) ____________

64-Slice CT

IV Contrast ☐ if indicated ☐ No

Creatinine level ____________ Date ____________

- ☐ Brain
- ☐ Sinuses ☐ Coronal ☐ Axial
- ☐ Neck (soft tissue)
- ☐ Breast
- ☐ Chest
- ☐ Abdomen
- ☐ Pelvis
- ☐ Temporal Bones
- ☐ Extremity ____________
- ☐ Spine/Other ____________

Speciality Exams

☐ Calcium Score ☐ 3D Recon ☐ CT Urogram

Check the following if a contrast study:

☐ Asthma ☐ Diabetes

☐ Contrast Allergy ☐ Renal Insufficiency

MRA

- ☐ Carotids to include Arch
- ☐ Circle of Willis
- ☐ 3D Recon
- ☐ Peripheral w/ Runoffs
- ☐ Renal
- ☐ Aorta

CTA

- ☐ Coronary
- ☐ Carotids
- ☐ Thoracic Aorta
- ☐ 3D Recon
- ☐ Renal
- ☐ Abdominal Aorta
- ☐ Abdominal Aorta w/runoffs
- ☐ Circle of Willis

Special Instructions

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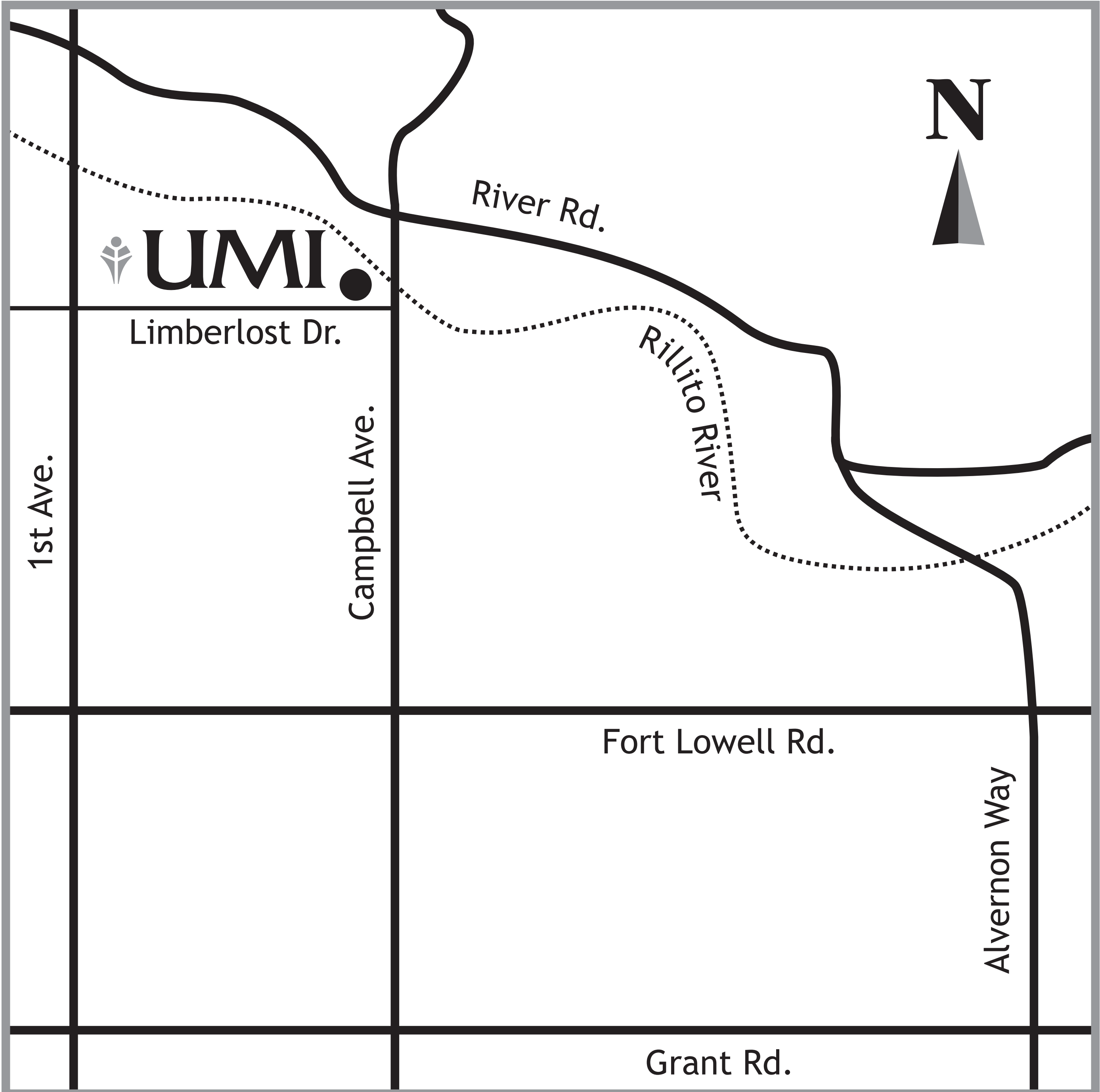
4291 N. Campbell Ave. • Tucson, AZ 85719 • Main line: (520) 425-8900 • Fax line: (520) 425-8990 • www.umiaz.com
Scheduling: (520) 425-8999

Map



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