UNIVERSITY OF VIRGINIA HEALTH SYSTEM
DEPARTMENT OF RADIOLOGY/UVA IMAGING
DOWNTIME MRI IMAGING REQUEST FORM

PLACE LABEL HERE

Ordering Date_____

MRN# _____
IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

Please **Fax to** (434) 244-9408
Schedule at (434) 243-2700

***If Pt has Pacemaker or Cochlear Implant, MRI is contraindicated.

Patient Name:_____

Pre/Post-op Y N Date of Surgery_____ MR#_____

DOB ____/____/____ Weight: _____ Phone #_____

Insurance Company & Plan	Pre Authorization Number	Attending MD/Pic #	Ordering MD/Pic #

Referring Clinic/Office Where Report Should Be Sent	Phone Number of Contact Person Name	Box & Fax Number

Physician Signature _____

STUDY DESIRED (Circle Side if appropriate)

X	Study	X	Study
	Common MRI Procedures		
	Brain MRI (*orbit x-ray, 2-3 D recon, MRA as medically necessary)		Cardiac MRI (*orbit x-ray, 2-3 D recon, MRA as medically necessary)
	Facial Bones/ Orbits MRI (*orbit x-ray, 2-3 D recon, MRA as medically necessary)		Chest MRI (*orbit x-ray, 2-3 D recon, MRA as medically necessary)
	Temporal Bones MRI (*orbit x-ray, 2-3 D recon, MRA as medically necessary)		Abdomen MRI (*orbit x-ray, 2-3D recon, MRA as medically necessary)
	Sinus MRI (*orbit x-ray, 2-3 D recon, MRA as medically necessary)		Pelvis MRI (*orbit x-ray, 2-3 D recon, MRA as medically necessary)
	Soft Tissue Neck MRI (*orbit x-ray, 2-3 D recon, MRA as medically necessary)		Upper Extremity MRI LT RT (*orbit x-ray, 2-3 D recon, MRA as medically necessary)
	Cervical Spine MRI (*orbit x-ray, 2-3 D recon, MRA as medically necessary)		Lower Extremity MRI LT RT (*orbit x-ray, 2-3 D recon, MRA as medically necessary)
	Thoracic Spine MRI (*orbit x-ray, 2-3 D recon, MRA as medically necessary)		MR Angio Chest # (*orbit x-ray, 2-3 D recon, MRA as medically necessary)
	Lumbar Spine MRI (*orbit x-ray, 2-3 D recon, MRA as medically necessary)		MR Angio Abdomen # (*orbit x-ray, 2-3 D recon, MRA as medically necessary)
	Cisternogram MRI (*orbit x-ray, 2-3 D recon, MRA as medically necessary)		MR Angio Pelvis # (*orbit x-ray, 2-3 D recon, MRA as medically necessary)
	MR Angio Head # (*orbit x-ray, 2-3 D recon, MRA as medically necessary)		MRA Upper Extrem LT RT # (*orbit x-ray, 2-3 D recon, MRA as medically necessary)
	MR Angio Neck # (*orbit x-ray, 2-3 D recon, MRA as medically necessary)		MRA Lower Extrem LT RT # (*orbit x-ray, 2-3D recon, MRA as medically necessary)
	Breast LT RT (*orbit x-ray, 2-3 D recon, MRA as medically necessary)		

Protocol (Internal Use ONLY):

Any Exam Not Listed (Specify):

Clinical Indications for Exam (Mandatory): **Unless Specified, IV contrast will be decided upon by the Radiologist**

Relevant Signs/Symptoms Diagnosis (MANDATORY--MUST be ICD-10 Numeric Code): ie-786.2

Are there any special considerations for pts safety? (E.g. non-English speaking, sz disorder, pregnancy, M.R., medications that could affect pt. Testing) Explain: _____

Is there a Hx of Metal in Eyes? ☐**Yes** ☐**No**

Is Patient Claustrophobic? ☐**Yes** ☐**No**

Is Sedation required? ☐**Yes** ☐**No** **(Pediatric/Claustrophobic patients may require sedation)**

☐ *Please check here if you do not wish the Radiologist to determine medical necessity.

 # = Codes that Require Medical Necessity for MRA

0700001

MRI IMAGING REQUEST