

HIGH FIELD IMAGING MRI SCHEDULING SHEET
995 Greentree Rd. Pgh, PA 15220
Phone: 412-920-0100 Fax: 412-922-8169

Patient's Name _____
 Date of Birth _____ Height _____ Weight _____
 Home Phone _____ Work _____ Cell _____
 Primary Insurance _____ ID _____ Grp _____
 Secondary Insurance _____ ID _____ Grp _____

Ordering Physician _____
 Phone _____ ****FAX**** _____
 (to receive reports)

MRI: _____ with contrast _____ w/o contrast

___ Brain	___ TMJ **	___ L ___ R
___ Sinuses	___ Shoulder	___ L ___ R
___ Orbits	___ Elbow	___ L ___ R
___ IAC's	___ Forearm	___ L ___ R
___ Pituitary	___ Wrist	___ L ___ R
___ Cervical	___ Hand	___ L ___ R
___ Lumbar	___ Femur	___ L ___ R
___ Thoracic	___ Lower Leg	___ L ___ R
___ Pelvis	___ Knee	___ L ___ R
___ Abdomen*	___ Ankle	___ L ___ R
___ Kidney*	___ Foot	___ L ___ R
___ Liver *	___ Hip	___ L ___ R
___ Adrenals*	___ Breast**	___ L ___ R

***CLOSED UNIT PREFERRED**
****CLOSED UNIT ONLY**

MRA
 ___ Brain
 ___ Carotids*

***CLOSED UNIT ONLY**

Diagnosis _____

Please complete the following questions concerning your personal health history. If you answer **yes** to any, please call us at 1-877-MRPETCT (677- 3828) Please bring any associated MRI, CT films or reports with you to your appointment.

Pacemaker	Yes	No	Prosthetic devices	Yes	No
Metal in your eyes	Yes	No	Breastfeeding	Yes	No
Stents	Yes	No	Chance of pregnancy	Yes	No
Aneurysm clips	Yes	No	Body piercing	Yes	No
Insulin pumps	Yes	No			
Heart valve	Yes	No	Any surgery on:		
Claustrophobic	Yes	No	___ Spine	Date: _____	
Diabetic	Yes	No	___ Brain	Date: _____	
Tattoos	Yes	No	___ Other	_____	
Implants (ie ear)	Yes	No			