KING STREET

1010 South King St. #109 Honolulu, HI 96814
PHONE: (808) 593-8080
FAX: (808) 593-1018

O STAT / URGENT

3TMRI • X-RAY APPOINTMENT

DATE: _____ O PATIENT CLAUSTROPHOBIC? PATIENT FOLLOW-UP

TIME: _____ O PACEMAKER OR METAL IMPLANTS? _____

PATIENT INFO AND INSURANCE

LAST: _____ FIRST: _____ O MALE O FEMALE

DOB: _____ HEIGHT/WEIGHT: _____ PHONE: _____

INSURANCE CARRIER: _____ AUTH #: _____

IF WORKERS COMP/AUTO PLEASE FILL OUT THE FOLLOWING: O WORK COMP O AUTO

DATE OF ACCIDENT: _____ CLAIM #: _____ EMPLOYER: _____

MRI REQUEST

HEAD AND NECK

- O BRAIN
- O IAC's
- O PITUITARY
- O ORBITS
- O FACE
- O NECK (SOFT TISSUE OR NASOPHARYNX)
- O OTHER (SPECIFY)

_____

O MRA O MRV

- O INTRACRANIAL (HEAD)
- O EXTRACRANIAL (NECK)
- O OTHER (SPECIFY)

_____

SPINE

- O CERVICAL
- O THORACIC
- O LUMBAR
- O BURKHALTER
- O SACRUM
- O SI JOINTS

MUSCULOSKELETAL

- O JOINT (SPECIFY)

_____

- O FOOT
  - O FOREFOOT
  - O MID FOOT
  - O HIND FOOT / ANKLE
- O OTHER (SPECIFY)

_____

IV CONTRAST O YES O NO O ARTHROGRAM O PER RADIOLOGIST

X-RAY REQUEST

O ORBITS			O KUB				O FINGER	_____			
O CHEST	1V	2V	O RIBS	L	R	B	O KNEE	L	R	B	
O C-SPINE	3V	7V	O HIP	L	R	B	O ANKLE	L	R	B	
O T-SPINE			O SHOULDER	L	R	B	O FOOT	L	R	B	
O L-SPINE	3V	5V	O WRIST	L	R	B	O TOE	_____			
O PELVIS			O HAND	L	R	B	O OTHER	_____			

DIAGNOSIS OR REASON FOR EXAM

ICD10 CODE (REQUIRED): _____ PREVIOUS IMAGING _____

DIAGNOSIS/INDICATION: _____

SYMPTOMS/COMPLAINTS: _____

MASS OR TUMOR O KNOWN O SUSPECTED PRIOR SURGERY: _____

REQUESTING PROVIDER _____ PHONE: _____

CC TO: _____ PHONE: _____

PROVIDER SIGNATURE: _____ DATE: _____