To schedule call: 651-290-8707
Please complete and fax to: 651-726-2622

Patient Name: _____ Date of Birth: _____

Parent / Guardian: _____ Phone Number: _____

Appt. Preference: ☐ Today ☐ Specify, within: _____ days _____ weeks _____ months

Reason for Exam / Medical Necessity / Symptoms & Duration: _____

Dx (All indications): _____

MRI
HEAD
☐ Routine
☐ Quick/Shunt Series
☐ Orbit/Face/Sinus
☐ Pituitary
☐ IAC / IAM
SPINE
☐ Full Spine
☐ Screening
☐ Cervical
☐ Thoracic
☐ Lumbar
☐ L5-S1 (spondylo)
☐ SI Joints
☐ Multi Planar Reconstruction
ABDOMEN
☐ Kidneys
☐ Adrenals
☐ Liver
☐ MRCP
THORAX
☐ Sternum
☐ Soft Tissue Neck
MR ANGIO
☐ Head
☐ Neck
☐ Chest / Pulmonary
☐ Aortic Arch
☐ Renals/SMA
☐ Upper Extremity
☐ Lower Extremity

MRI	
LOWER EXTR	Specify
☐ Full Lower Ext	☐ Left ☐ Right ☐ Bilat
☐ Pelvis	
☐ Hip	☐ Left ☐ Right ☐ Bilat
☐ Hip Quick/Screening	☐ Left ☐ Right ☐ Bilat
☐ Femur	☐ Left ☐ Right ☐ Bilat
☐ Knee	☐ Left ☐ Right ☐ Bilat
☐ Tib / Fib	☐ Left ☐ Right ☐ Bilat
☐ Ankle	☐ Left ☐ Right ☐ Bilat
☐ Foot	☐ Left ☐ Right ☐ Bilat
☐ Toe	Specify Digit: _____
UPPER EXTR	Specify
☐ Brachial Plexus	☐ Left ☐ Right ☐ Bilat
☐ Shoulder	☐ Left ☐ Right ☐ Bilat
☐ Clavicle	☐ Left ☐ Right ☐ Bilat
☐ Scapula	☐ Left ☐ Right ☐ Bilat
☐ Humerus	☐ Left ☐ Right ☐ Bilat
☐ Elbow	☐ Left ☐ Right ☐ Bilat
☐ Forearm	☐ Left ☐ Right ☐ Bilat
☐ Wrist	☐ Left ☐ Right ☐ Bilat
☐ Hand	☐ Left ☐ Right ☐ Bilat
☐ Finger(s)	Specify Digit: _____
MR ARTHROGRAM	
☐ Joint _____	☐ Left ☐ Right

MRI Screening	YES	NO
Aneurysm clip	☐	☐
Cardiac Pacemaker	☐	☐
Cochlear Implant	☐	☐
Metal Implant/devices within body	☐	☐
Baclofen pump	☐	☐
Bivona trach	☐	☐
Claustrophobic	☐	☐
ADHD or developmental delay	☐	☐
Respiratory concerns	☐	☐
Programmable shunt	☐	☐
Managed by: _____		
Vagus Nerve Stimulator (VNS)	☐	☐

SCHEDULED FOR:

Date / Time: _____

Arrival Time: _____

Preparation: _____

Pre-Notification #: _____

IV CONTRAST:	YES	NO
IV Contrast	☐	☐
Previous contrast reaction (If yes, order prep)	☐	☐
Diabetes	☐	☐
Kidney Disease or Dialysis	☐	☐
INSTRUCTIONS:		
Allergies: _____	☐	☐
MRSA	☐	☐
Ventilator dependent	☐	☐
Pregnant	☐	☐
Child Life Services	☐	☐
Interpreter needed:	☐	☐
Language: _____		
Previous Images (Non-Gillette):	☐	☐
Location: _____ Date: _____		

Fax outside Reports to Gillette Imaging: Fax: 651-229-3921

Mail CD or film copies to: Gillette Childrens Imaging Dept.
200 University Ave E
St. Paul, MN 55101

SEDATION: Requires H&P within 7 days ☐ ☐
Fax H&P to 651-726-2643

Other Orders / Instructions:

Provider Name: _____ **Signature:** _____ **Date**: _____
Print/ Stamp here

Phone Number: _____ **Address:** _____

0118-906
01/11

Outside Provider MRI Order