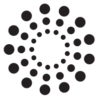
MRI EXAM ORDER FORM



CHEYENNE RADIOLOGY

Date: _______/_______/_______   Appointment Date & Time: _______/_______/_______   _____:_______ ☐ AM ☐ PM

Patient Name: ____

Date of Birth: ________/________/________

Study Requested: ____

____

Symptoms / History: ____

Physician Signature: ______________________ Printed: ______________________

Routine: ______________ Phone Report: ______________

Please ask your patients the following questions to ensure their exam is scheduled correctly.

Have you ever done any welding or grinding? ☐ YES ☐ NO

If yes, the patient must have an x-ray to clear orbits before MRI exam.

Any metal in the body? ☐ YES ☐ NO

* If yes, explain: ____

Any surgery in the past 6 weeks? ☐ YES ☐ NO

* If yes, explain: ____

Claustrophobia ☐ YES ☐ NO

Surgery on the area being examined ☐ YES ☐ NO

History of Cancer ☐ YES ☐ NO *If yes, explain: ______________________

Pacemaker ☐ YES ☐ NO

Cranial Aneurysm Clip ☐ YES ☐ NO

Weigh more than 300 pounds ☐ YES ☐ NO *If yes, how much: ______________________

Thank you for choosing Cheyenne Radiology & MRI. If you have any questions or concerns, feel free to contact our office at 307-634-7711.