TALLAHASSEE DIAGNOSTIC IMAGING
MRI

CDS/AUC: G-Code: _____ Modifier: _____

Tallahassee Diagnostic Imaging
1600 Phillips Road
Tallahassee, FL 32308
Phone: 850-878-4127
Fax: 850-878-9729

Express MRI
2459 Mahan Drive
Tallahassee, FL 32308
Phone: 850-702-0939

Appointment Date
____ / ____ / _____
_____ AM / PM

MRI ORDER

Weight _____
(*over 350 lb include height*)

Patient Name _____ Date of Birth _____

Referring Facility _____

Contact & Direct Line _____ Auth # (if required) _____

☐ Perform blood creatinine (contrast patients only) per TDI protocol if no labs done within 6 weeks* of scheduled study if patient has HTN / Diabetes / 60 years of age / Single Kidney / Renal Cancer / Lupus / Liver Disease / Renal TXP
**If patient has had blood creatinine labs within 6 weeks, please send results to TDI*

☐ **MRI Contrast/Gadolinium Allergy**
Referrer to Prescribe Premedication
Prior Reaction: _____

Pertinent History/Clinical Indication _____

☐ Contrast at Rad's Discretion

Head & Neck MRI	CONTRAST w/o & With	CONTRAST W/Out
☐ Brain	☐	☐
☐ Cranial Nerve	☐	
☐ IAC's	☐	☐
☐ Pituitary – Sella	☐	☐
☐ Orbits	☐	☐
☐ Sinuses	☐	☐
☐ Soft Tissue Neck	☐	☐
☐ TMJ		☐
Spine MRI		
☐ Cervical	☐	☐
☐ Thoracic	☐	☐
☐ Lumbar	☐	☐
☐ Sacrum/Coccyx	☐	☐
☐ SI Joints	☐	☐

Ortho MRI			CONTRAST w/o & With	CONTRAST W/Out
☐ Hand	L	R	☐	☐
☐ Wrist	L	R	☐	☐
☐ Elbow	L	R	☐	☐
☐ Shoulder	L	R	☐	☐
☐ Foot	L	R	☐	☐
☐ Ankle	L	R	☐	☐
☐ Knee	L	R	☐	☐
☐ Hip	L	R	☐	☐
☐ Thigh	L	R	☐	☐
☐ Lower Leg	L	R	☐	☐
☐ Toe _____	L	R	☐	☐
☐ Finger _____	L	R	☐	☐
MRA				
☐ Circle of Willis (Head)			☐	☐
☐ Carotids/Vertebrals			☐	☐
☐ Renal (MRA)			☐	☐
☐ Specify _____			☐	☐

Body MRI	CONTRAST w/o & With	CONTRAST W/Out
☐ Abdomen	☐	☐
☐ Pelvis Soft Tissue	☐	☐
☐ Pelvis Boney (MSK)	☐	☐
☐ Brachial Plexus	☐	☐
☐ MRCP (Abdomen)		☐
☐ Adrenal (Abdomen)		☐
☐ Kidney	☐	☐
☐ Pancreas	☐	
☐ MRI Breast:	☐	
☐ Implant Integrity		☐
☐ MRI Guided Breast Biopsy	☐	

Arthrogram & Fluoro Joint Injection

☐ Right ☐ Left

☐ Joint _____

Specify Other MRI / Attention To

☐ _____

IMPORTANT: MUST BRING THIS FORM WITH YOU TO YOUR APPOINTMENT.
– Please do not bring children to be left unattended –

Physician's Signature **Printed Physician Name** **Date**

PLEASE SEND ORDER TO TDI AND GIVE PATIENT A COPY