Columbia Radiology MRI Center at Neurological Institute

COLUMBIA UNIVERSITY COLLEGE OF PHYSICIANS & SURGEONS

Today's Date:______________________________

Patient's Name: ____ Date of Birth: ________ MRN: __________________________

Home Ph: (   ) ___________________________ Work/Cell Ph: (   ) ___________________________ INS Name:_________________

Ins ID#________________________________ Name of Insured: ______________________Pre-Certification#: _______________________

Ordering Physician:__________________________________Phone: (   ) ____________________ Fax: (   ) ____________________

Scheduling:

Routine - Next Available Appointment ☐ Same day as Physician Appt ☐ Date/Time: ____________________________

Same Day Scan (Reading) **Urgent** ☐ Number to call if different from above ____________________________ / Routine ☐

MRI:

☐ Without Contrast ☐ With Contrast ☐ With & Without Contrast

☐ Brain ☐ Skull Base ☐ IAC's

☐ Neck ☐ Pituitary

☐ C-Spine ☐ T-Spine ☐ L-Spine ☐ Brachial Plexus

☐ Orbits ☐ L – S Plexus

Special Instructions: ____________________________

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MRA:

☐ Without Contrast ☐ With Contrast ☐ With & Without Contrast

☐ Brain ☐ Neck ☐ Aortic ☐ Other ____

CT:

☐ Without Contrast ☐ With Contrast ☐ With & Without Contrast

☐ Brain ☐ Sinuses ☐ Abdomen

☐ C-Spine ☐ Pituitary ☐ Pelvis

☐ T-Spine ☐ Neck ☐ Chest

☐ L-Spine ☐ Facial Bones ☐ CTA Brain ☐ CTA Neck

Special Instructions: ____________________________

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Clinical Information:

Relevant Information: ____

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BUN / CREAT: (if contrast ordered) ________________________________Date: ___________________ ICD-9 Code: _____________________

Implantable Device: ☐ YES ☐ NO (If Yes, Please Specify) ____

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For Internal Use Only:

Scheduled Location:____Appt Date / Time: ___________________________

Contact Name:____ Contact Ph#:_____________________________________

Columbia Radiology MRI Center at Neurological Institute

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