MICHIGAN STATE UNIVERSITY HEALTHTEAM

Department of Radiology
MSU Clinical Center, Ste D100 (D-Wing)
840 Service Rd, East Lansing, MI 48824

MR Referral Form

Ph 517-353-5053 (Ext 1)
Fax 517-432-4394
www.rad.msu.edu

Tax ID 386005984
NPI 1891747614

Patient Name _____ DOB _____ Phone _____

Diagnosis/ICD Code(s) _____

Reason for Test or Referral/Signs & Symptoms _____

Injury Date _____ ☐Male ☐Female Weight _____

Insurance Type(s) _____ Precertification Number _____

Please Fax Referral Form with insurance Card(s)—front and back

MRI

Head
- ☐ Brain
- ☐ Iac (Internal Auditory Canals)
- ☐ Orbits
- ☐ Pituitary
- ☐ TMJ (Temporo-Mandibular Joint)

Spine
- ☐ Cervical
- ☐ Thoracic
- ☐ Spinal Cord _____
- ☐ Lumbar (LS/Lumbo Sacral)
- ☐ Sacrum
- ☐ Sacroiliac (S.I.) Joint

Upper Extremities & Joints
- ☐L ☐R Shoulder
- ☐L ☐R Scapula
- ☐L ☐R Upper Arm (Humerus)
- ☐L ☐R Elbow
- ☐L ☐R Lower Arm (Radius/Ulna)
- ☐L ☐R Wrist
- ☐L ☐R Hand

Lower Extremities & Joints
- ☐L ☐R Hip
- ☐L ☐R Upper Leg (Femur)
- ☐L ☐R Knee
- ☐L ☐R Lower Leg (Tibia/Fibula)
- ☐L ☐R Ankle (Includes Achilles)
- ☐L ☐R Foot

PRE-SCREENING

Please answer the following questions to assist with scheduling.

Pacemaker	☐YES	☐NO
Aneurysm Clip	☐YES	☐NO
Metal (e.g. metal in eyes, surgical implants, etc.)	☐YES	☐NO
Stent(s)	☐YES	☐NO
Prior surgery to the area being scanned	☐YES	☐NO
Pregnant	☐YES	☐NO

MR ANGIOGRAPHY (MRA)
- ☐ Head Angiography (Cerebral)
- ☐ Neck Angiography (Carotid & Vertebral)
- ☐ Upper Extremity Angiography
- ☐ Chest Angiography
- ☐ Spinal Canal Angiography
- ☐ Abdomen/Renal Angiography
- ☐ Pelvis Angiography
- ☐ Lower Extremity Angiography

MRI/ARTHROGRAMS
- ☐L ☐R MRI/Arthrogram Shoulder
- ☐L ☐R MRI/Arthrogram Elbow
- ☐L ☐R MRI/Arthrogram Wrist
- ☐L ☐R MRI/Arthrogram Hip
- ☐L ☐R MRI/Arthrogram Knee
- ☐L ☐R MRI/Arthrogram Ankle

MISCELLANEOUS
- ☐ Neck (Soft Tissue)
- ☐L ☐R Brachial Plexus
- ☐ Chest
- ☐ Breast MRI (Bilateral)
  Attn: ○ Lt ○ Rt
- ☐L ☐R Breast Biopsy (MRI-Guided)
- ☐ Abdomen (NPO 4 hours)
- ☐ Pelvis (NPO 4 hours)
- ☐ Spectroscopy
  (Also select anatomy)
- ☐ Magnetic Resonance Venogram (MRV)
- ☐ Other _____

MR exams with and/or without contrast will be performed per Radiologist's protocol. If you would NOT like contrast administered, check this box: ☐ *Please explain:* _____

Referring Physician/Provider Information

Signature or stamp X _____

Printed Name _____

Form filled out by _____

Office Phone _____

Office Fax _____

Print, Sign & Fax END OF FORM