EAST TENNESSEE Children's Hospital

If the MRI is considered urgent,
please call the Radiology RN
at 865-541-8116

MRI Physician Order

STEP 1 **COMPLETE** all information and **FAX** to Radiology: 865-541-8287 Date:____/____/____

Patient's Name: _____ DOB: ____/____/____

Address: _____

Phone: ( ) _____ Alternate phone: ( ) _____

Responsible adult;contact name:_____(mom/dad/other) Patient's Wt._____ Ht._____

CHECK EXAM ORDERED

____ Abdomen
____ Brain
____ C-Spine
____ T-Spine
____ L-Spine
____ Cardiac
____ Chest
____ Entire Spine
____ MRA
____ MRCP
____ Pelvis
____ Extremity (please specify)
____ ✓ Consult for sedation/anesthesia based on patient screening characteristics

Contrast Requested: ____ Without ____ With and Without

Reason for Exam: _____

_____

_____

_____

_____

_____

_____

_____

_____

*****Please fax current H & P if patient will require sedation or is less than 12 years old*****

Physician's Signature **(REQUIRED):**_____

Print Physician's Name:_____

Office Phone: ( ) _____ Fax: ( )_____

STEP 2 **Appointment Completed by Radiology and Faxed to Ordering Physician**
(Radiology staff calls family for medical history and schedules MRI)

Appointment Date/Time:_____

STEP 3 **Ordering Physician office obtains precert # and faxes this completed form to Admitting 865-541-8289 at least 24 hours prior to the appointment. Scheduled exams will not be performed without a precert #.**

Primary Insurance: _____

Precertification #: _____

ICD.10 Code: _____ **CPT CODE:** _____

If you have any questions, please leave a voicemail at 865-541-8398 for our nurse scheduler.

Form No. 30403 (12/2020) ss