



THE UNIVERSITY of TEXAS
HEALTH SCIENCE CENTER
AT HOUSTON

UTHSC MRI Center

6431 Fannin, G.605 Houston, TX 77030
Tel: (713)500-6916 Fax: (713)500-0698

EXAMINATION ORDER FORM

SCAN TIME/DATE: _____ NAME (Study name or Code number): _____
 PATIENT NAME: _____ PT ID# _____
 PATIENT D.O.B.: _____ AGE: _____ GENDER: MALE FEMALE
 PATIENT IS: RIGHT HANDED or LEFT HANDED HEIGHT: _____ WEIGHT: _____
 REFERRING PHYSICIAN: Beauchamp PHONE: x5978 FAX: _____
 DIAGNOSIS: N/A

PLEASE CHECK EXAM REQUIRED BELOW

MRI of Head & Neck

_____ Temporomandibular Joint
 _____ Orbits/ Face/ Neck
 _____ Head, Attention to IACS
 Brain Without Contrast
 _____ Brain With & Without Contrast*
 _____ Pituitary With & Without Contrast*

MRI of Spine

_____ Cervical Without Contrast
 _____ Cervical Spine With & Without Contrast*
 _____ Thoracic Without Contrast
 _____ Thoracic With & Without Contrast*
 _____ Lumbar Without Contrast
 _____ Lumbar With & Without Contrast*

MRI of Extremities

_____ LEFT Knee
 _____ RIGHT Knee

MRI of Abdomen & Pelvis

_____ Abdomen
 _____ Pelvis

MRA

_____ Head
 _____ Neck

*** REQUIRED INFORMATION FOR ALL CONTRAST ORDERS:**

- Contrast Injection X 1 dose via IVP / Injector (dose 0.2ml/kg with Max dose of 20ml)
- Patient who has a history of Diabetes Mellitus and/or Renal disease will need a STAT Creatinine done (if no serum creatinine has been performed in the last 2 weeks.)

MD Signature: _____

Date: _____

Special Instructions: _____

PRIMARY INVESTIGATOR SIGNATURE: _____

ACCOUNT NUMBER FOR CHARGE: 02-25520000-37518-10-11730-67248