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: ____ 713-500-5978 FAX: _____

DIAGNOSIS: _____

***PLEASE CHECK EXAM REQUIRED BELOW***

## *MRI of Head & Neck*

_____ Temporomandibular Joint
_____ Orbits/ Face/ Neck
_____ Head, Attention to IACS
**X** 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 is > 50 years old and/or with history or Kidney disease will need an STAT Creatinine done (if no serum creatinine has been performed in the last 2 weeks.)

MD Signature: _____

***Special Instructions:*** _____

**PRIMARY INVESTIGATOR SIGNATURE:** 

**Charge To:**

| Unit | Dpt | Fund | Prjct | Prgm | Acct | Class |
|---|---|---|---|---|---|---|
| | 25520000 | 50000 | 7425 | 13 | | |