

RADIOLOGY ASSOCIATES OF WAUSAU, S.C.
OPEN MRI OF WAUSAU
www.openmriofwausau.com

Patient Name: _____ D.O.B.: _____ Phone: _____

Referring M.D.: _____ Phone: _____ Fax: _____

Patient History/Symptoms: _____

Previous Related Imaging: _____

(Send images and report to OPEN MRI **PRIOR** to patient's MRI appointment.)

Can patient stand and pivot on their own?	No	Yes	
Is there any history of contrast reaction?	No	Yes	(If yes, then consider premedication)
Will patient be bringing sedation?	No	Yes	
Is the patient potentially pregnant?	No	Yes	
Is there a history of metal in the eyes/orbits?	No	Yes	(If yes, then include request for x-ray of orbits to screen for metallic foreign body one hour prior to MRI appointment)
Contraindications to MRI: Aneurysm clips? Pacemaker? Defibrillator? Other?			
Prior Surgery in area to be scanned?	No	Yes	(If yes, then describe _____)
Patient Height: _____	Weight: _____		

A. SITE TO BE IMAGED, CIRCLE THE SPECIFIC LOCATION WITHIN EACH ORGAN SYSTEM

- () Abdomen Liver Biliary (MRCP) Adrenal Kidney
() Brain Routine IAC Pituitary Pineal
() Brain MRA () Carotid MRA
() Chest (plain) Aorta Chest Wall Mediastinum Heart
() Extremity Joint(s) () Right () Left
 Ankle Elbow Foot Finger/Hand Knee Shoulder Wrist Other _____
() Orbits / Face / Neck () TMJ
() Pelvis Female Pelvic Organs Hips Sacrum Lumbosacral Plexus
() Spine Cervical Thoracic Lumbar
() Vascular/MRA – Aorta (Thoracic or Abdominal), Pelvis, Renal Arteries, Abdominal Visceral Arteries
() Other _____ Please Specify _____

B. CONTRAST (Circle One): 1. Without 2. Without and With 3. Defer Decision to Radiologist

Please mail available correlating films with date of OPEN MRI exam to:

OPEN MRI Scheduling
c/o Radiology Film Tracking
333 Pine Ridge Blvd
Wausau, WI 54401

Important phone numbers: Scheduling – 715-847-2020 or Toll-free 888-616-5611

After scheduling, please FAX this form to – 715-241-5411 / Attention: Open MRI Scheduling

The patient should report to **Aspirus Weston Clinic, 4005 Community Center Drive, Weston, WI**
(Map and directions are available at www.openmriofwausau.com)

Appointment Date: _____ Time: _____

Ordering M.D. Signature: _____ Date: _____