

IF FAXING AN ORDER, PLEASE INCLUDE:

- Demographics
- Insurance card
- Clinical notes

HOURS OF OPERATION

Mon - Fri 7 a.m. - 10 p.m.
Sat 8 a.m. - 6 p.m.

WALK-IN X-RAY*

Mon - Fri 8:00 a.m. - 4 p.m.

*To confirm availability, call in advance.

SPRINGFIELD

3640 Main St., Suite 101
Springfield, MA 01107



Appointment date and time		Check-in time	Patient DOB	Sex assigned at birth <input type="radio"/> M <input type="radio"/> F
Patient name (as shown on insurance card)		Primary phone #	Secondary phone #	
Patient address				
<input type="radio"/> Auto <input type="radio"/> Workers' comp <input type="radio"/> Commercial/Private	Date of injury	Insurance name	Insurance ID #	Authorization #

(REQUIRED) Written diagnosis/reason/symptom for exam(s). Must include **specific** clinical indications (such as location, context and severity) to support medical necessity for each test.

Is the exam/procedure related to an injury? No Yes **If yes** Initial Subsequent or Sequela

MRI	CT	ULTRASOUND
<p style="text-align: center;"><input type="radio"/> IV contrast as clinically indicated by radiologist OR <input type="radio"/> No contrast</p> <p>EQUIPMENT PREFERENCE <input type="radio"/> High-field open MRI <input type="radio"/> 3T MRI <input type="radio"/> No preference</p> <p>NEURO <input type="radio"/> Brain and/or <input type="radio"/> Orbits <input type="radio"/> IAC <input type="radio"/> Pituitary <input type="radio"/> Volumetric brain imaging (NeuroQuant®) - What are you looking to measure? _____</p> <p>Spine <input type="radio"/> Cervical <input type="radio"/> Thoracic <input type="radio"/> Lumbar <input type="radio"/> Sacrum/coccyx <input type="radio"/> Neck (soft tissue) <input type="radio"/> Brachial plexus</p> <p>MUSCULOSKELETAL <input type="radio"/> Extremity non-joint _____ <input type="radio"/> L <input type="radio"/> R <input type="radio"/> BIL <input type="radio"/> Extremity joint _____ <input type="radio"/> L <input type="radio"/> R <input type="radio"/> BIL <input type="radio"/> TMJ bilateral</p> <p>BODY <input type="radio"/> Abdomen <input type="radio"/> MRCP w/3D reconstruction <input type="radio"/> Pelvis <input type="radio"/> Chest <input type="radio"/> Enterography (abdomen/pelvis)</p> <p>MRA <input type="radio"/> Brain <input type="radio"/> Neck/Carotids <input type="radio"/> Arch <input type="radio"/> Renal arteries <input type="radio"/> Aorta <input type="radio"/> Extremity _____ <input type="radio"/> L <input type="radio"/> R <input type="radio"/> BIL</p> <p>OTHER <input type="radio"/> _____</p>	<p style="text-align: center;"><input type="radio"/> IV contrast as clinically indicated by radiologist OR <input type="radio"/> No contrast</p> <p>NEURO <input type="radio"/> Brain <input type="radio"/> IAC <input type="radio"/> Orbits</p> <p>Spine <input type="radio"/> Cervical <input type="radio"/> Thoracic <input type="radio"/> Lumbar <input type="radio"/> Sinus <input type="radio"/> Temporal bones <input type="radio"/> Facial bones <input type="radio"/> Neck (soft tissue)</p> <p>MUSCULOSKELETAL <input type="radio"/> Extremity _____ <input type="radio"/> L <input type="radio"/> R <input type="radio"/> BIL <input type="radio"/> Extremity joint _____ <input type="radio"/> L <input type="radio"/> R <input type="radio"/> BIL</p> <p>BODY <input type="radio"/> Abdomen <input type="radio"/> Pelvis <input type="radio"/> Abdomen & pelvis <input type="radio"/> Chest <input type="radio"/> Urogram (abdomen/pelvis) <input type="radio"/> Enterography (abdomen/pelvis) <input type="radio"/> Kidney stone (abdomen/pelvis)</p> <p>SCREENING <input type="radio"/> Cardiac calcium scoring</p> <p>CTA <input type="radio"/> Brain <input type="radio"/> Chest <input type="radio"/> Neck/Carotids <input type="radio"/> Renal arteries <input type="radio"/> Aorta <input type="radio"/> Extremity _____ <input type="radio"/> L <input type="radio"/> R <input type="radio"/> BIL</p> <p>OTHER <input type="radio"/> _____</p>	<p style="text-align: center;"><input type="radio"/> Doppler as clinically indicated by radiologist OR <input type="radio"/> No Doppler</p> <p style="text-align: center;"><input type="radio"/> Transvaginal as clinically indicated by radiologist OR <input type="radio"/> No transvaginal</p> <p><input type="radio"/> Abdomen <input type="radio"/> Complete <input type="radio"/> Limited <input type="radio"/> Aorta <input type="radio"/> Aorta aneurysm screening <input type="radio"/> Renal <input type="radio"/> Bladder <input type="radio"/> Pelvis <input type="radio"/> Complete <input type="radio"/> Limited <input type="radio"/> Pelvis/Transvaginal <input type="radio"/> Scrotum/Doppler <input type="radio"/> Soft tissue abdomen <input type="radio"/> Thyroid <input type="radio"/> Vascular studies <input type="radio"/> Carotid <input type="radio"/> L <input type="radio"/> R <input type="radio"/> BIL <input type="radio"/> Venous leg <input type="radio"/> L <input type="radio"/> R <input type="radio"/> BIL <input type="radio"/> Venous arm <input type="radio"/> L <input type="radio"/> R <input type="radio"/> BIL <input type="radio"/> Non-vascular extremity _____ <input type="radio"/> L <input type="radio"/> R <input type="radio"/> BIL <input type="radio"/> Other _____</p>
		X-RAY
<p>Views _____ <input type="radio"/> Chest <input type="radio"/> Abdomen (KUB) Spine <input type="radio"/> Cervical <input type="radio"/> Thoracic <input type="radio"/> Lumbar <input type="radio"/> Extremity _____ <input type="radio"/> L <input type="radio"/> R <input type="radio"/> BIL <input type="radio"/> Orbits screening pre-MRI <input type="radio"/> Other _____</p>		

REPORTING METHOD <input type="radio"/> Report only <input type="radio"/> Report & CD <input type="radio"/> Web viewing <input type="radio"/> Phone report _____ <input type="radio"/> Fax report _____		
Provider name (print)	Provider location City/Zip	Phone #
Provider signature (required) Do not use rubber stamp.	NPI # (required for new providers)	Date

PATIENT PREPARATION

MRI

Please inform us if you have a pacemaker, cardiac defibrillator, ICD, cochlear ear implants or severe renal disease, are on dialysis, have had an injury to your eyes with metal or have any metal objects in your body.

CT

Procedures with IV contrast:

No food two (2) hours prior to your procedure. Inform the office if you have kidney disease, are on dialysis or are taking medications. Drink plenty of liquids the day prior to the exam and water up to exam time for hydration.

Procedures without contrast:

No preparations are required.

ORAL CT CONTRAST

Do not eat or drink anything for four (4) hours prior to your exam (with the exception of the oral contrast). We recommend you hydrate with water up to the time of your appointment for your benefit.

Your medications may be taken with water.

ULTRASOUND

Abdomen (includes gallbladder, liver, pancreas, spleen, biliary tract, common bile duct, kidneys and aorta)

Nothing to eat or drink six (6) hours prior to examination. Prescription medication may be taken with a small amount of water.

Pelvic/Urinary bladder

- a. One and one half (1½) hours before the exam is scheduled, drink 32 oz. of fluid (water, tea, coffee, etc.). No orange juice, milk or carbonated beverages.
- b. You should finish drinking one (1) hour before exam time.
- c. **Do not empty bladder** one (1) hour before (this study requires that your bladder be full. This may result in an uncomfortable feeling).
- d. You may eat and drink up to one (1) hour before exam time.

X-RAY

No preparations are required.

SPECIAL INSTRUCTIONS

Patient should bring any CDs related to the imaging procedure to be performed. Any sedation or pain medication for a procedure must be prescribed by the patient's provider. Inform the office if you are or may be **pregnant** or are a **nursing mother**.

SPRINGFIELD

3640 Main St., Suite 101
Springfield, MA 01107

LEGAL NAME

Chelmsford MRI PC

TAX ID 04-3133041

NPI 1386662112*

**For Medicaid, Medicare, RR Medicare and Medicare Crossover Claims to BCBS, use NPI 1821435553.*

FROM THE NORTH - ROUTE 91S TO EXIT 8:

- Make a right at the end of the exit onto Birnie Ave.
- At the end of the street, make a right onto Wason Ave.
- Proceed to the end of the street, make a left onto Main St.
- The center is on the left at 3640 Main St.
- The center is located on the first floor, Suite 101

FROM THE SOUTH - ROUTE 91N TO EXIT 8:

- Make a left off the ramp at the light onto Main St.
- The center is on the left at 3640 Main St.
- The center is located on the first floor, Suite 101

