Clear Form

Neuro Imaging Winter Park

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Patient Name: _____ Date of Birth: _____
Patient Phone(s): _____ Follow up Appointment Date/Time: _____
Diagnosis/Clinical Concern: _____
Pertinent History/Comments: _____
Referring Physician: _____ Phone: _____
Referring Physician Signature: _____ Date: _____

Please select from each category:

A. Modality:
- ◯ MRI - 3T Open Bore
- ◯ CT - Multidetector
  - ☐ Add 3D

B. Intravenous Contrast:
- ◯ Yes
- ◯ No
- ◯ Radiologist Discretion

C. Sedation
- ◯ No
- ◯ Oral
- ◯ Intravenous

D. Side
- ◯ Left
- ◯ Right
- ◯ Bilateral
- ◯ Not Applicable

PLEASE SELECT ONE OR MORE EXAMS:

BRAIN
- ☐ Brain
- ☐ Internal Auditory Canals
- ☐ CSF Flow Supply
- ☐ Spectroscopy/Perfusion
- ☐ MR Pituitary
- ☐ Orbits
- ☐ Pediatric Ventricular Shunt Study

SPINE
- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbosacral
- ☐ MR Myelography

HEAD AND NECK
- ☐ Temporal Bone/Skull Base
- ☐ Neck Soft Tissue
- ☐ Paranasal Sinus
- ☐ Facial Bones
- ☐ MR Brachial Plexus
- ☐ TMJ MR: ☐ Add Cine

MUSCULOSKELETAL
Add Arthrogram ☐ Yes ☐ No
- ☐ Shoulder
- ☐ Arm
- ☐ Forearm
- ☐ Elbow
- ☐ Wrist
- ☐ Hand/Thumb/Digit
- ☐ Hip
- ☐ Pelvis
- ☐ Sacrum/Coccyx
- ☐ Thigh
- ☐ Knee
- ☐ Lower Leg
- ☐ Ankle
- ☐ Forefoot

MR/CT ANGIOGRAPHY
- ☐ Cerebral
- ☐ Carotid
- ☐ Thoracic Outlet
- ☐ Thoracic Aorta
- ☐ Abdominopelvic
- ☐ Renal Arteries
- ☐ Extremity: ☐ Lower ☐ Upper

ABDOMEN
- ☐ Abdomen
- ☐ MRCP
- ☐ Pancreas
- ☐ Kidneys
- ☐ Liver

PELVIS
- ☐ Pelvis
- ☐ MR Uterus/Adnexa
- ☐ Pelvis Floor Laxity MR

CHEST
- ☐ Chest CT
- ☐ MR Mediastinum/Chest Wall
- ☐ Breast Implant Rupture

MR VENOGRAPHY
- ☐ Cerebral
- ☐ Extremity: ☐ Lower ☐ Upper

MRI IS CONTRAINDICATED FOR PATIENTS WITH NON-TITANIUM ANEURYSM CLIPS, PACEMAKERS, AND NOT RECOMMENDED IN FIRST TRIMESTER PREGNANCY

Rev. 09-14