Kootenai Outpatient Imaging - MRI SCHEDULING / ORDERS

Phone: 208.625.6380 Fax: 208.625.6381

Appointment date:_____ Time:_____ ❑ am ❑ pm Check in:_____ ❑ am ❑ pm

Appointment location: ❑ KOI-CDA ❑ KOI-Post Falls ❑ Hospital (south entrance)

Patient name (print):_____ Birthdate: _____

Parent's name (if patient is a minor): _____

Primary phone:_____ Secondary phone: _____

Insurance authorization #:_____ Scheduled by:_____ Taken by: _____

Primary insurance: _____ Policy #: _____ Group #: _____

Secondary insurance:_____ Policy #:_____ Group #: _____

Ordering / Referring Provider name (print): _____

CC Provider(s):_____

Provider Signature:_____ **Date:**_____ **Time:**_____

WARNING Answering yes to some of these questions could be a contraindication for having an MRI scan, and may be life threatening to the patient. Please answer them appropriately.

Does this patient have?

❑ Yes ❑ No *****Pacemaker or Cardiac Defibrillator
❑ Yes ❑ No *****Loop Recorder or other Cardiac Device
❑ Yes ❑ No *****Heart Valve or Stent
❑ Yes ❑ No *****Vascular Stent
❑ Yes ❑ No *****Brain Aneurysm Clips
❑ Yes ❑ No *Brain Shunt
❑ Yes ❑ No *Deep Brain Stimulator (DBS)
❑ Yes ❑ No *****Implanted Stimulator (Nerve,Spinal,Bladder or other)
❑ Yes ❑ No *Cochlear Ear or Staples Implant
❑ Yes ❑ No *****Implanted Device or Pump (Gastric Reflux,Breast Expander,Penile,other)
❑ Yes ❑ No Removable Drug Pump (Pain or Diabetic)
❑ Yes ❑ No Metal in your body

*****Please fax a patient information card containing Model Number and Serial Number of the implant.

❑ Yes ❑ No Metal in your eyes
❑ Yes ❑ No Eye or Eyelid Surgery
❑ Yes ❑ No Prosthesis or Brace
❑ Yes ❑ No Continuous Glucose Monitor
❑ Yes ❑ No Electronic Pill Camera
❑ Yes ❑ No Medication Patch (Some patches will need to be removed for MRI, discuss with scheduler).
❑ Yes ❑ No Allergies _____
❑ Yes ❑ No Pregnant or Nursing
❑ Yes ❑ No History of Cancer: type _____
❑ Yes ❑ No Tattoos
❑ Yes ❑ No Permanent Cosmetics
❑ Yes ❑ No Magnetic Eyelashes
❑ Yes ❑ No Dental Implants
❑ Yes ❑ No Hearing Aides
❑ Yes ❑ No Body Piercings (must be removed)

Claustrophobic and Needs_____Oral_____Anesthesia**** **** Fax a History and physical.**

Anesthesia will not be scheduled without attempting oral meds first.

MRI - Magnetic Resonance Imaging

Head
❑ Routine
❑ Cranial Nerves (Brain)
❑ Orbits
❑ IAC (Brain)
❑ MS (Brain)
❑ Sella (Pituitary)

Spine
❑ Cervical
❑ Thoracic
❑ Lumbar
❑ Bone Marrow

Torso
❑ Soft Tissue Neck
❑ Chest
❑ Abdomen Routine
❑ Abdomen with MRCP
❑ Abdomen with Eovist
❑ Abdomen / Pelvis Enterography

Joint
❑ Knee R L
❑ Shoulder R L
❑ Ankle R L
❑ Elbow R L
❑ Wrist R L
❑ Hips R L

Extremity
❑ Forearm R L
❑ Hand R L
❑ Humerus R L
❑ Brachial Plexus R L

Torso
❑ Pelvis (Bone)
❑ Pelvis (Soft Tissue)
❑ Pelvis (Prostate CA)
❑ Breast with CAD evaluation
❑ Breast for implant evaluation
❑ Breast biopsy and diagnostic mammo
❑ Cardiac

❑ Forefoot R L
❑ Hindfoot R L
❑ Toes R L

Contrast - Radiologist discretion will be used, unless you specify one of these three options
❑ Without contrast
❑ Arthrogram contrast ❑ With & Without contrast

MRA - Magnetic Resonance Angiography
❑ Head (Arterial) ❑ Neck (extra) ❑ Run-off
❑ Head (Venous) ❑ Renal
❑ Other _____

Please specify narrative diagnosis with ICD-10 Code(s)

What is the clinical question you are trying to answer?

Note: *To ensure correct and appropriate patient care and comply with federal rules and regulations, MRI's policy is to require a written order from the treating provider. The order must include signs and symptoms pertinent to the exam, type of exam requested, and the provider's signature.*

Other: _____

Patient Instructions _____ ▶

Patient Identification - Write in or attach patient label
Name:
MRN #:
CSN #:

KootenaiHealth

Referral Attachment
920030-009

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Exam Preparation Information **Any Questions,** call 208.625.6380

This information is pertinent to all MRI's

- If you have prosthesis or an implanted device such as a pacemaker, aneurysm clip, cochlear implant, please bring the card that you were given at the time of your surgery. We will need that information in order to investigate whether you can safely have an MRI scan. If you do not have your card, please call **(208) 625-6380** prior to your appointment so we may assist you in getting the information.
- For your safety, you will be required to change out of your clothing and into our cotton hospital gowns.
- Please arrive 30 minutes before your scheduled appointment time.

The physical address of our 3 locations are:

(Please confirm which site your exam has been scheduled at)

❑ **Kootenai Health (Hospital)**
2003 Kootenai Health Way, CDA

❑ **Kootenai Outpatient Imaging**
700 Ironwood Drive, Suite 175, CDA

❑ **Kootenai Health Park**
1300 E Mullan Ave, Post Falls

- Please remove ***ALL body piercings***. The magnetic field may cause the metal to heat up and burn you. For YOUR SAFETY, they must be removed. If you must remove the piercings while you are in MRI, please bring the appropriate tools to do so.
- Please leave your valuables at home. You will need your driver's license and insurance cards to present upon check in.
- In consideration of the patients that follow you, we ask that you refrain from wearing perfume as the smell lingers past your visit and can be irritating to others.

❑ **Abdomen MRI, MRCP Abdomen MRA, Renal MRA, and Run-off MRA**

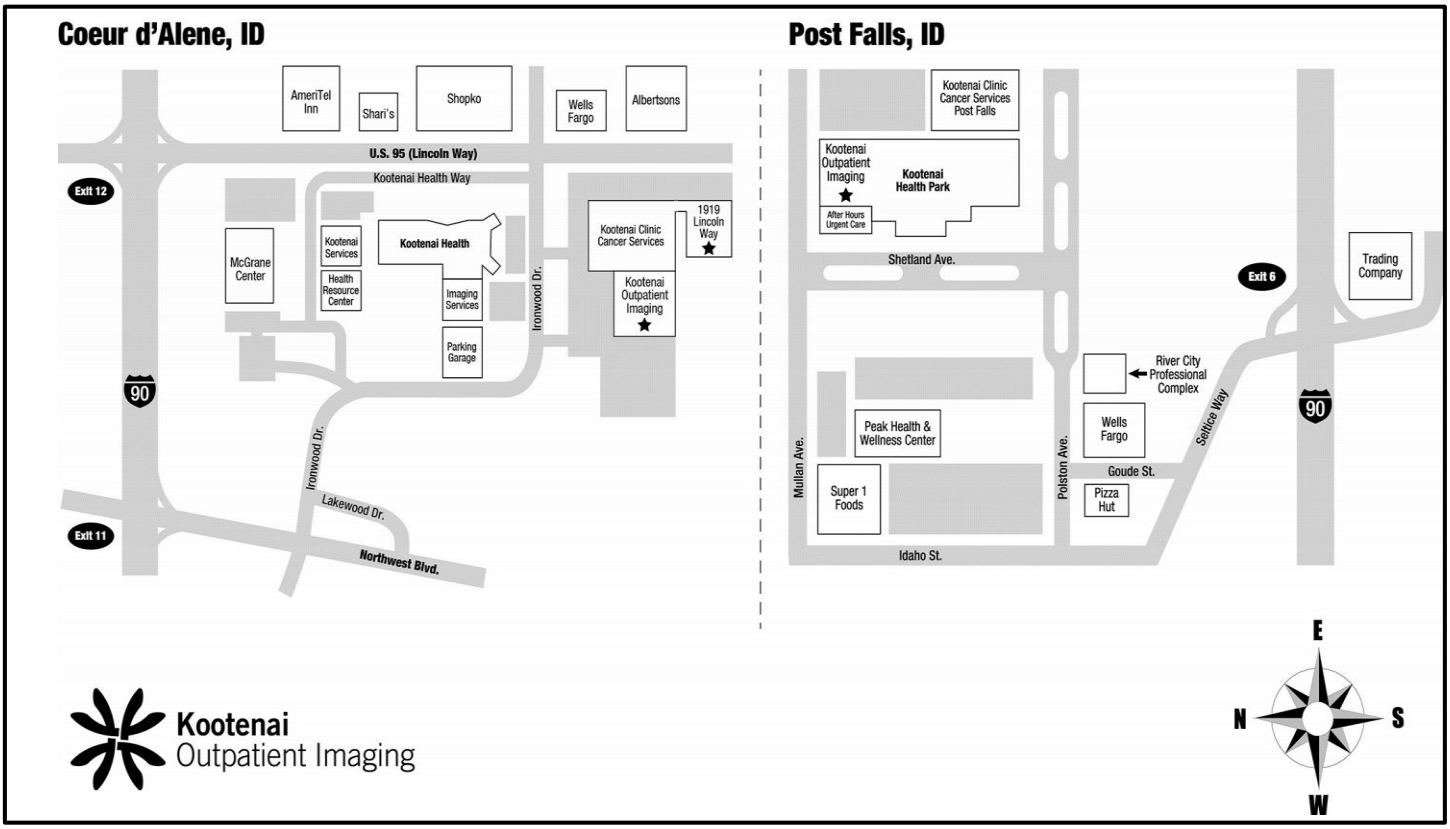
- Please have nothing to eat or drink for 4 hours prior to your study. Taking your prescribed medications with a small sip of water is okay.

❑ **Anesthesia - ADULT (This must be ordered by the referring physician.)**

- Please have nothing to eat or drink for 8 hours prior to your study. Taking your prescribed medications with a small sip of water is okay.
- Bring a list of the medications that you are currently taking.
- You will need a driver to escort you home after your procedure.

❑ **Anesthesia - PEDIATRIC (This must be ordered by the referring physician.)**

- You will receive a phone call from our nurse to discuss your child's eating and drinking restrictions.
- Do not let your child have a full night's sleep on the eve of their study. Having your child be tired will allow us to use less medication and be safer for them.
- Please bring a list of medications that your child is currently taking.
- Your child must not be left alone for 24 hours following the study. Please coordinate appropriate child care arrangements.



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