North DeKalb Orthopedics

Diagnostic Management, Inc.

NORTH DEKALB ORTHOPEDICS, PC

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Patient Name_____ **Date Ordered**_____

Tel Number: _____ Height _____ Weight _____

❑ Claustrophobic ❑ Previous Surgery ❑ Pacemaker ❑ Metal ❑ Pregnant

Brief History: _____

_____

_____

_____

MRI SCAN

❑ SPINE
- ❑ Cervical
- ❑Thoracic
- ❑ Lumbar

❑ SHOULDER	R	L
❑ ELBOW	R	L
❑ WRIST	R	L
❑ HIP/PELVIS	R	L
❑ KNEE	R	L
❑ FOOT/ANKLE	R	L

CONTRAST/GADOLINIUM
❑ YES ❑NO

MRI ARTHROGRAM
❑ YES ❑NO
❑ Other MRI: _____

_____

Physical Findings
- ☐ Hx previous surgery
- ☐ Degenerative changes on X-Ray
- ☐ Radiating pain to Arm/Leg
- ☐ St Leg Raise
- ☐ Medial Joint Line Tenderness
- ☐ Lateral Joint Line Tenderness
- ☐ Locking ☐ Swelling
- ☐ Paresthesias
- ☐ Appley compression/ McMurrays
- ☐ Clicking/Popping
- ☐ Instability / Giving Way
- ☐ Impingement
- ☐ Weakness/numbness

Other Conservative Treatment
- ☐ Physical Therapy
- ☐ Anti-Inflammatory
- ☐ Other_____

PAIN MANAGEMENT
❑ Epidural Blocks
❑ Trigger Point Injections
❑ Series ❑ Single

CT SCAN
❑ CT Pelvis
❑ CT Cervical Spine
❑ CT Thoracic Spine
❑ CT Lumbar Spine
❑ Other_____

_____

MYELOGRAM
☐ YES ☐ NO

ARTHROGRAM
❑ Wrist ☐ Other _____
❑ Knee
❑ Shoulder

NUCLEAR_____
❑ Bone Scan ❑ Gallium Scan
❑ Total Body
❑ Section_____

NEUROLOGIC TESTING
❑EMG_____
❑NCV_____

Notes:_____

_____

_____

Diagnosis:_____

_____

Based upon this Patient's history, exam, & diagnosis, I have requested the above test(s). I hereby certify that the tests were medically necessary for the Diagnosis & Treatment of this patient. The patient listed above agrees to have DMI schedule and pre-certify this diagnostic procedure. Note: This is a Physician's Order for Diagnostic Procedures and Other Procedures

DMI Phone 770-507-8199 Fax 770-507-9566

Physician Signature_____