FACSIMILE

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NORTH HAWAI'I COMMUNITY HOSPITAL
AN AFFILIATE OF THE QUEEN'S HEALTH SYSTEMS

To: **Imaging Department MRI Scheduler** From:

Fax: **808-881-4841** Tel:

Tel: **808-881-4842** Date:

Of Pages with Cover Page: Time:

Patient Name:

Subject: **MRI Exam Order**

CONFIDENTIAL HEALTH INFORMATION ENCLOSED. Health Care Information is personal and sensitive information related to a person's health care. It is being faxed to you after appropriate authorization from the patient or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient authorization or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

The following are included with this fax:

- ☐ Exam order with proper physician signature and appropriate diagnosis --- both legible
- ☐ Prior relevant images are en route:
  - ☐ CD
  - ☐ Hard copy films
  - ☐ N/A

Comments:

- ☐ Applicable prior-authorization
- ☐ Applicable Labs
- ☐ Required forms for this exam:
  - ☐ Patient Checklist for CT and MRI Contrast Exams
  - ☐ MRI Consultation Request
  - ☐ Patient Prescreening Questionnaire for MRI Contrast Exams
  - ☐ Breast Diagram form
- ☐ Applicable implant information

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RADIOLOGY OUTPATIENT - EXAM REQUEST

PATIENT'S LAST NAME:	PATIENT'S PHONE NUMBER:	SEX:	DATE OF BIRTH:	EXAM DATE & TIME:
PATIENT'S FIRST NAME:	WRITTEN DIAGNOSIS & ICD-9 CODE REQUIRED FOR EACH EXAM ORDERED:			
ORDERING PROVIDER (Please print):				
PROVIDER SIGNATURE:	INSURANCE PROVIDER:		INSURANCE MEMBERSHIP NUMBER:	
PROVIDER PHONE #:	PRE-APPROVAL: [ ] YES [ ] NO		PRE-APPROVED BY:	
COPY TO PRIMARY PROVIDER:	DATE OF ACCIDENT:	[ ] WORK COMP [ ] NO FAULT	AUTHORIZATION NUMBER:	
PRIORITY: [ ] Routine [ ] Urgent	ADJUSTER'S NAME:		IF WORKCOMP, NAME OF EMPLOYER:	
[ ] CALL PROVIDER WITH RESULTS. PHONE NUMBER TO CALL:				

PATIENT: Bring insurance or preauthorization with you, arrive 30 minutes prior to exam and go directly to Registration.

RADIOLOGY

- ☐ Abdomen 2 views
- ☐ Acute Abdomen Series
- ☐ Ankle 3+ views ☐ RT ☐ LT
- ☐ Cervical Spine
- ☐ Chest PA & LAT
- ☐ Clavicle ☐ RT ☐ LT
- ☐ Elbow 3+ views ☐ RT ☐ LT
- ☐ Femur ☐ RT ☐ LT
- ☐ Finger ☐ RT ☐ LT
- ☐ Foot 3+ views ☐ RT ☐ LT
- ☐ Forearm ☐ RT ☐ LT
- ☐ Hand 3+ views ☐ RT ☐ LT
- ☐ Heel ☐ RT ☐ LT
- ☐ Hip ☐ RT ☐ LT
- ☐ Humerus ☐ RT ☐ LT
- ☐ Knee 1-2 views ☐ RT ☐ LT
- ☐ Knee 3 views ☐ RT ☐ LT
- ☐ Knee 4+ views
- ☐ Lumbar Spine Complete
- ☐ Pelvis
- ☐ Ribs and PA Chest ☐ RT ☐ LT
- ☐ Scapula ☐ RT ☐ LT
- ☐ Scoliosis
- ☐ Shoulder ☐ RT ☐ LT
- ☐ Sinus ☐ RT ☐ LT
- ☐ Thoracic Spine ☐ RT ☐ LT
- ☐ Tibia/Fibula ☐ RT ☐ LT
- ☐ Toe ☐ RT ☐ LT
- ☐ Wrist 3 views ☐ RT ☐ LT

FLUORO

- ☐ Arthrogram ☐ Upper GI
- ☐ Esophagram ☐ PICC line
- ☐ Barium Enema

BIOPSY (fill in type of biopsy)

MRI

Contrast checklist required for all exams scheduled with contrast

- ☐ Ankle ☐ MRA Head ☐ Lumbar
- ☐ Arthogram ☐ Foot ☐ MRCP
- ☐ Brain ☐ Head ☐ Pelvis
- ☐ Breast ☐ Hip ☐ Shoulder
- ☐ Cervical ☐ Knee ☐ Thoracic
- ☐ Elbow ☐ Liver ☐ Wrist
- ☐ Face/Neck ☐ MRA Arch/Carotid
- ☐ Extremity: ☐ Upper ☐ Lower ☐ RT ☐ LT
- ☐ Other:

- ☐ Previous surgery in area of scan?

ANSWER ALL OF THE BELOW FOR ALL MRIs:

- [ ] yes [ ] no Cardiac Pacemaker
- [ ] yes [ ] no Claustrophobia
- [ ] yes [ ] no History of Orbital Foreign Body
- [ ] yes [ ] no Implant - specify:
- [ ] yes [ ] no Pregnancy

CT

Contrast checklist required for all exams scheduled with contrast

- ☐ Abdomen ☐ Lower extremity
- ☐ Abdomen/Pelvis ☐ Lumbar
- ☐ Brain/Head ☐ Pelvis
- ☐ Cervical ☐ Pelvis
- ☐ Chest ☐ Pelvis
- ☐ Chest/Abd/Pelvis ☐ Pelvis

ULTRASOUND

- ☐ Abdomen complete ☐ Pelvic
- ☐ Abdomen limited ☐ Paracentesis
- ☐ Abdomen aorta ☐ Renal
- ☐ Bladder (w/post void residual) ☐ Scrotum
- ☐ Thyroid
- ☐ Carotid Duplex ☐ Thoracentesis
- ☐ Echocardiogram
- ☐ Arterial Doppler: ☐ Lower ☐ Ext ☐ RT ☐ LT
- ☐ Arterial Doppler: ☐ Upper ☐ Ext ☐ RT ☐ LT
- ☐ Venous Doppler: ☐ Lower ☐ Ext ☐ RT ☐ LT
- ☐ Venous Doppler: ☐ Upper ☐ Ext ☐ RT ☐ LT

OB ULTRASOUND

- ☐ OB - 1st trimester (up to 14 wks)
- ☐ OB - 20 weeks and over
- ☐ OB - LTD (for growth)
- ☐ OB - Follow up (viability, placenta, AFI, cx length)

NUCLEAR MEDICINE

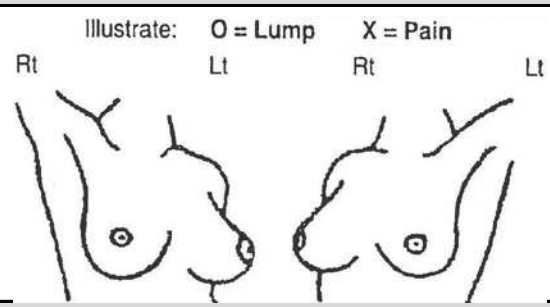
For specific Nuclear Medicine exams, please request using the empty space on the bottom of this form.

- ☐ Bone Scan ☐ Liver Scan
- ☐ Gastric Emptying ☐ Lung Scan
- ☐ Hepatobiliary (HIDA) ☐ Thyroid Scan
- ☐ Kidney (specify) ☐ Thyroid Uptake

BREAST SERVICES

Screening and additional Imaging if indicated.
(Authorization is given to schedule additional views and/or ultrasound if needed as per Radiologist).

- ☐ Screening Only
- ☐ Diagnostic ☐ RT ☐ LT
- ☐ Diagnostic with Breast US if indicated
- ☐ Breast Ultrasound
- ☐ Needle Aspiration or Biopsy



OTHER EXAM(s) NOT SHOWN ABOVE / ADDITIONAL COMMENTS:

FAX to 881-4841 to SCHEDULE an appointment.

Questions? Please call 881-4880. FAX to 881-4896 for NON-SCHEDULED appointment.

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Patient Checklist for CT and MRI Contrast Exams

Please check below if patient has any of the following indications for the risk of contrast-induced renal insufficiency. A recent creatinine level result must be available prior to a scheduled imaging exam that requires the administration of intravenous contrast and gadolinium-based agents for patients with:

- ☐ 1. Patient or family history of hereditary renal disease, such as Autosomal Dominant Polycystic Disease (ADPCKD)
- ☐ 2. Diabetes Mellitus for 2 years or more, or currently taking Metformin (Glucophage)
- ☐ 3. Age > 60 years
- ☐ 4. Other risk factors for chronic renal disease
- ☐ 5. Hx renal surgery or solitary renal disease
- ☐ 6. Nephrotic medications (i.e. chemotherapy, aminoglycosides)
- ☐ 7. Renal infections or calculi
- ☐ 8. Multiple Myeloma
- ☐ 9. Congestive Heart Failure or other cause of poor cardiac output and reduced renal flow
- ☐ 10. Dehydration
- ☐ 11. Kidney neoplasm
- ☐ 12. ***Pregnant***
- ☐ 13. ***Allergic to IV contrast***
- ☐ 14. None of the above

Recent Creatinine & GFR no less than 6 months

Patient Name_____ Office Signature_____ Date_____

List of patient's allergies and medications are also required. Please use space below.

_____

_____

_____

Technologist Use Only

Contrast Clearance: □ verified eGFR _____ □ not cleared eGFR _____
□ eGFR results attached are within 6 weeks of MRI contrast procedure _____(initials)

IV Site:_____ Number of Attempts:_____ Time Given:_____ am/pm

Contrast Name/ml:_____/ml Exp:_____/_____/_____ Lot:_____

Comments/Reactions: _____

NORTH HAWAI'I COMMUNITY HOSPITAL
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MRI Service
Appts/Info: 881-4842
Fax: 881-4841

MRI Consultation Request

PATIENT INFORMATION

Name: _____ Date of Birth:: _____ Sex: _____
Last First M.I.

Home Phone: _____ Business/cell phone: _____

Address: _____ Weight: _____

MRI EXAMINATION

Exam(s) Requested: **MRI of** _____ MRI exam CPT code(s) _____

History / Indication (and/or ICD code): _____

Previous surgery in area of scan: _____

Previous comparison studies: ☐ NO ☐ YES If yes, please circle: MRI CT X-RAY US NM

Location and date of previous studies, if known: _____

Previous images and reports will be transported to NHCH. by: ☐ Courier ☐ Mail ☐ Patient

PHYSICIAN INFORMATION

_____ _____ _____
Ordering Physician (please print): Signature (do not print or stamp) Date

Physician phone: _____ Physician FAX: _____

Report will be faxed to number in our system. If that has recently changed, please note new fax: _____

Additional report copies to Dr(s): _____

ABSOLUTE CONTRAINDICATIONS		
Cardiac pacemaker	☐ NO	☐ YES
Cerebral aneurysm clip	☐ NO	☐ YES
Neurostimulator	☐ NO	☐ YES

RELATIVE CONTRAINDICATIONS		
Pregnancy	☐ NO	☐ YES
Claustrophobia	☐ NO	☐ YES
History of orbital foreign body	☐ NO	☐ YES

Patients are screened for other contraindications prior to exam*

PATIENT INSURANCE INFORMATION

Insurance Carrier: _____ Membership Number: _____

Pre-authorization: ☐ YES ☐ Pending Pre-approved by: _____

If accident, date of accident: _____ ☐ Workman's Comp ☐ No fault

Authorization number: _____ Adjuster's name: _____

If Workman's Comp, name of employer: _____

SCHEDULING INFORMATION

Appointment date: _____

Appointment time: _____

Arrival time: _____

This space for MRI Department Use Only:

SCANNING PROTOCOL ☐ Routine ☐ Other:

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Patient Prescreening Questionnaire for MRI Contrast Exams

Patient Name:_____
(Last) (First) (Middle)

Patient D.O.B. _____/_____/_____ Appointment Date: _____ Time: _____am/pm

Chief Complaint: _____

Please circle one:

YES	NO	Are you over the age of 60?
YES	NO	Are you diabetic or have a history of diabetes mellitus?
YES	NO	Do you have a history of hypertension?
YES	NO	Do you have a history of renal or kidney disease?
YES	NO	Have you seen a kidney specialist or nephrologist for a kidney problem?
YES	NO	Do you have a history of receiving chemotherapy?

Due to the increased risk for Nephrogenic Systemic Fibrosis (NSF) in patients with abnormal kidney function, which may result in fatal or debilitating systemic fibrosis; those patients that answered YES to any of the above questions will need to obtain blood work (Basic Metabolic Profile – BMP) with Serum Creatinine/Globmerular filtration rate (eGFR) prior to their contrast procedure to evaluate kidney function.

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Patient's Signature: _____ Date: _____

RT Signature: _____ Date: _____

□ reviewed/cleared by technologist
Date: _____

□ reviewed/cleared by technologist after speaking with patient
Technologist Initials:_____

Technologist Use Only

Contrast Clearance: □ verified eGFR _____ □ not cleared eGFR _____
□ eGFR results attached are within 6 weeks of MRI contrast procedure _____(initials)

IV Site:_____ Number of Attempts:_____ Time Given:_____ am/pm

Contrast Name/ml:_____/ml Exp:_____/_____/_____ Lot:_____

Comments/Reactions: _____

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Breast Diagram Form

For breast imaging orders including mammography, MRI and ultrasound:
If the order form you are using does not include this illustration,
please complete the diagram below and submit with your order.