

**MRI of Springfield**  
ACR Accredited MRI Center  
Phone (417) 885-1100  
Fax (417) 885-1109

**1420 E. Bradford Parkway**  
Springfield, Missouri 65804  
just South of Primrose & Fremont  
800-MRI-STAT (674-7828)

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**Magnetic Resonance Imaging.....MRI..... Patient order.....**

**Patient Name:** \_\_\_\_\_

**Date of Exam:** \_\_\_\_\_ **Time of Exam:** \_\_\_\_\_

**TYPE OF STUDY(IES) REQUESTED:**

- |   |                                   |                            |                            |
|---|-----------------------------------|----------------------------|----------------------------|
| <input type="checkbox"/> Brain              | <input type="checkbox"/> Shoulder | <input type="checkbox"/> L | <input type="checkbox"/> R |
| <input type="checkbox"/> Neck (soft tissue) | <input type="checkbox"/> Elbow    | <input type="checkbox"/> L | <input type="checkbox"/> R |
| <input type="checkbox"/> Pituitary          | <input type="checkbox"/> Wrist    | <input type="checkbox"/> L | <input type="checkbox"/> R |
| <input type="checkbox"/> Cervical Spine     | <input type="checkbox"/> Hip      | <input type="checkbox"/> L | <input type="checkbox"/> R |
| <input type="checkbox"/> Thoracic Spine     | <input type="checkbox"/> Knee     | <input type="checkbox"/> L | <input type="checkbox"/> R |
| <input type="checkbox"/> Lumbar Spine       | <input type="checkbox"/> Ankle    | <input type="checkbox"/> L | <input type="checkbox"/> R |
| <input type="checkbox"/> Abdomen            | <input type="checkbox"/> MRA      | _____                      | _____                      |
| <input type="checkbox"/> Pelvis             | <input type="checkbox"/> Other    | _____                      | _____                      |

Gadolinium Requested     Gadolinium if Appropriate     Request images sent to my office

Send Patient Images & Report for consultation with: \_\_\_\_\_

**Diagnosis/Reason for Exam** \_\_\_\_\_

**Ordering Physician:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

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