CLEARVIEW MRI

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☐ 17885 NW Evergreen Pl Suite 100, Beaverton, OR 97006 | Fax: (503) 746-7905

Patient Name: _____ Date of Birth: _____

Patient Phone Number: _____

Insurance: _____ Insurance ID/Claim: _____

Referring Physician (print): _____

Referring Physician Signature (required): _____

Symptoms/Diagnosis/Reason for Exam(s): *Include clinical indications to support medical necessity*

_____

MRI EXAMS:

☐ WITH CONTRAST IF CLINICALLY INDICATED

- ☐ MRI Brain
  - ☐ Pituitary Protocol
  - ☐ IAC Protocol
  - ☐ Trigeminal Protocol
- ☐ MRA Brain/Head/COW
- ☐ MRI Cervical Spine
- ☐ MRA Neck/Carotids
- ☐ MRI Cranio-Cervical
- ☐ MRI Thoracic Spine
- ☐ MRI Lumbar Spine
- ☐ MRI SI Joints
- ☐ MRI Abdomen
- ☐ MRI Pelvis
  - ☐ Female Pelvis Protocol

- ☐ MRI Hip ..... ☐Left ☐Right
- ☐ MRI Knee ..... ☐Left ☐Right
- ☐ MRI Ankle/Hindfoot ..... ☐Left ☐Right
- ☐ MRI Forefoot ..... ☐Left ☐Right
- ☐ MRI Shoulder ..... ☐Left ☐Right
- ☐ MRI Elbow ..... ☐Left ☐Right
- ☐ MRI Wrist ..... ☐Left ☐Right
- ☐ MRI Hand/Finger ..... ☐Left ☐Right
- ☐ MR Arthrogram Shoulder ..... ☐Left ☐Right
- ☐ MR Arthrogram Wrist ..... ☐Left ☐Right
- ☐ MR Arthrogram Hip ..... ☐Left ☐Right
- ☐ MR Arthrogram Other _____

- ☐ MRI Other _____

X-RAY EXAMS:

- ☐ Cervical Spine – Routine Views
  - ☐ With Flexion & Extension
  - ☐ With Obliques
- ☐ Thoracic Spine – Routine Views
- ☐ Lumbar Spine – Routine Views
  - ☐ With Flexion & Extension
  - ☐ With Obliques
- ☐ Open Mouth Cervical L/R Lateral Bending
- ☐ Scoliosis Study
- ☐ Standing Bilateral Bone Length
- ☐ Pelvis
- ☐ X-Ray Other _____

- ☐ Hip ..... ☐Left ☐Right
- ☐ Knee ..... ☐Left ☐Right
- ☐ Ankle ..... ☐Left ☐Right
- ☐ Foot ..... ☐Left ☐Right
- ☐ Shoulder ..... ☐Left ☐Right
- ☐ AC Joints w/&w/o weights
- ☐ Elbow ..... ☐Left ☐Right
- ☐ Wrist ..... ☐Left ☐Right
- ☐ Hand ..... ☐Left ☐Right
- ☐ Ribs Bilateral
- ☐ Ribs Unilateral. ..... ☐Left ☐Right
- ☐ Chest 2V PA/LAT