EASTERN RADIOLOGISTS
GREENVILLE MRI

2101 W Arlington Blvd, Suite 110, Greenville, NC 27834
Open Mon–Fri 7am–9pm | Sat / Sun 8am–8pm
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FAX: 252.830.3689

Patient Name _____ DOB _____ Appointment Date / Time _____

Diag. Code _____ Clinical Information _____

Symptoms *(Please identify for each study)* _____

Physician Signature* _____ Physician Name _____

Requires original physician signature

Female Patient LMP _____ ☐ Perform urine pregnancy test? _____

Creatinine* _____ ☐ Perform Creatinine / BUN _____

**Provide Creatinine levels on any patient with Diabetes (within 1 week of appointment) and all patients over 55 years of age (within 3 months of appointment.)*

☐ STAT Report Fax# _____

BRAIN - NEURO

- ☐ Brain without
- ☐ Brain with / without contrast
- ☐ Orbits
- ☐ Internal Auditory Canal - Limited without contrast
- ☐ Internal Auditory Canal - Full with contrast
- ☐ Pituitary
- ☐ MRA Extracranial (EC) / Carotid Neck
- ☐ MRA Intracranial (IC) / Circle-of-Willis Head
- ☐ MRV Intracranial
- ☐ Full Brain and Head / Neck MRA
- ☐ Temporal Bone / IAC

SPINE

- ☐ Cervical without
- ☐ Cervical with / without contrast
- ☐ Thoracic without
- ☐ Thoracic with / without contrast
- ☐ Lumbar without
- ☐ Lumbar with / without contrast
- ☐ Total Spine *(Complete)* without
- ☐ Total Spine with / without contrast

ABDOMEN

- ☐ Abdomen
- ☐ Renal Mass
- ☐ Renal Artery
- ☐ Liver
- ☐ Liver / Eovist
- ☐ Adrenal
- ☐ MRCP with 3D Rendering
- ☐ Mesenteric MRA

ENT - NEURO

- ☐ Soft Tissue Neck
- ☐ Face / Sinuses
- ☐ Skull Base / Nasopharynx
- ☐ Trigemial Neuralgia
- ☐ Parotid / Salivary glands
- ☐ Thyroid
- ☐ Suprasellar / Parasellar
- ☐ Other _____

EXTREMITIES / ORTHO IMAGING

☐ Shoulder	☐ Rt.	☐ Lt.
☐ Shoulder Arthrogram	☐ Rt.	☐ Lt.
☐ Hip Unilateral	☐ Rt.	☐ Lt.
☐ Hip Arthrogram	☐ Rt.	☐ Lt.
☐ Hip Bilateral		
☐ Knee	☐ Rt.	☐ Lt.
☐ Ankle	☐ Rt.	☐ Lt.
☐ Foot	☐ Rt.	☐ Lt.
☐ Elbow	☐ Rt.	☐ Lt.
☐ Elbow Arthrogram	☐ Rt.	☐ Lt.
☐ Wrist	☐ Rt.	☐ Lt.
☐ Wrist Arthrogram	☐ Rt.	☐ Lt.
☐ Hand	☐ Rt.	☐ Lt.
☐ Pelvis - Bone		
☐ Sacrum / SI Joints		
☐ Other _____		

CHEST / CARDIAC IMAGING / VASCULAR

- ☐ Chest
- ☐ Chest Wall
- ☐ Thoracic Aorta
- ☐ Abdominal Aorta
- ☐ Aortogram and Run-off
- ☐ Brachial Plexus
- ☐ Extremity MRA *(Specify)* _____
- ☐ MR Venogram *(Specify)* _____

BREAST IMAGING

- ☐ Breast Unilateral ☐ Rt. ☐ Lt.
- ☐ Breast Bilateral
- ☐ MRI Guided Breast Biopsy

PELVIS

- ☐ Pelvis - Viscera
- ☐ Dynamic Pelvis / Pelvic Floor
- ☐ Uterine Fibroid Evaluation
- ☐ Other _____

OTHER

- ☐ X-Ray - Screening Orbits

Additional Comments _____