Cleveland Clinic

STAR Imaging

Tax ID # 34-1932969

Fax order to
937.312.1722
For questions, please call
937.435.6674

5529 Far Hills Avenue
Dayton, Ohio 45429
3.0T High Field
Open Bore MRI

PATIENT INFORMATION

Name _____

DOB _____ SS# _____

Home/Mobile phone _____

Work Phone _____

Height _____ Weight _____

Primary Insurance _____

Policy # _____

Precert # _____

Secondary Insurance _____

Policy # _____

MRI PROCEDURES

HEAD
- O Brain
- O Orbits
- O Pituitary
- O IAC's

SPINAL CORD
- O Cervical
- O Thoracic
- O Lumbar
- O Sacrum/Coccyx
- O SI Joints

- O Previous Surgery
- O No Previous Surgery

MUSCULOSKELETAL

Specify Side: O Left O Right O Bilateral

Lower
- O Femur
- O Hip
- O Knee
- O Tib/Fib
- O Hindfoot/ Ankle
- O Midfoot/ Forefoot/Toes

Upper
- O Hand
- O Wrist
- O Forearm
- O Elbow
- O Humerus
- O Shoulder

OTHER AREAS
- O Brachial Plexus
- O Neck, Soft Tissue
- O Chest
- O Abdomen
- O MRCP
- O Renals
- O Adrenals
- O Pelvis (Soft Tissue)
- O Pelvis (Bony)
- O Prostate
- O Other _____

MRI ANGIOGRAPHY
- O Head
- O Carotid
- O Chest
- O Abdomen
- O Pelvis
- O Renal
- O Upper Extremity
- O Lower Extremity
- O Runoff
- O OMRV
- O Other _____

BREAST
- O Bi-lateral

CONTRAST
O with O without O with & without O as per radiologist

Diagnosis / ICD10 _____

_____

Signs and Symptoms / Reason for Exam _____

_____

Physician Signature *(required)* _____

Date _____ Time _____

Referring Physician *(printed)* _____

Phone _____ Fax _____ Cell _____

Office Contact _____

Address _____

SCHEDULING INFORMATION

Date _____

Time _____

EXAM SCREENING

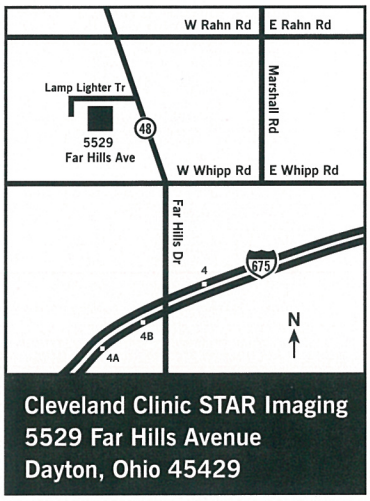
_____ Metal in eyes/body

_____ Aneurysm clips

_____ Pacemaker

_____ Claustrophobia

Please fax ID and insurance card(s)



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