Neurological Associates of Washington MRI

13107 121st Way NE, Kirkland, WA 98034
http://www.neuroassociates.us/

Specialty Neuroscience Protocols

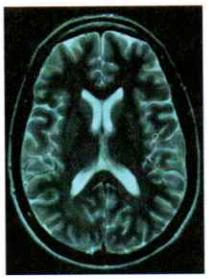
Scheduling: 425-658-3331 FAX: 425-284-1158

Patient Name: _____ DOB: _____ Primary phone: _____

Appointment Date: _____ Time: _____ Secondary phone: _____

Step 1: Select Specialty Protocol

BRAIN (with contrast? ☐) _____



☐ Routine G93.4 ☐ Headache R51 ☐ Dementia G30.9

☐ Head Injury S06890A ☐ Multiple Sclerosis G35 ☐ Convulsions R56.9

☐ Stroke I67.89 ☐ Tumor C71.9 ☐ Memory Loss R41.3

☐ Internal Aud. Canal D33.3 ☐ Pituitary/Sella D35.2 ☐ Postop G93.89

☐ Posterior Fossa G93.5 ☐ Meningioma D32.0 ☐ Other_____

C SPINE (with contrast? ☐) _____

☐ Radiculopathy M54.12 ☐ Soft Tissue Neck M54.2 ☐ Flexion M21.219

☐ Spinal Stenosis M48.02 ☐ Multiple Sclerosis G35 ☐ Other_____

T SPINE (with contrast? ☐) _____

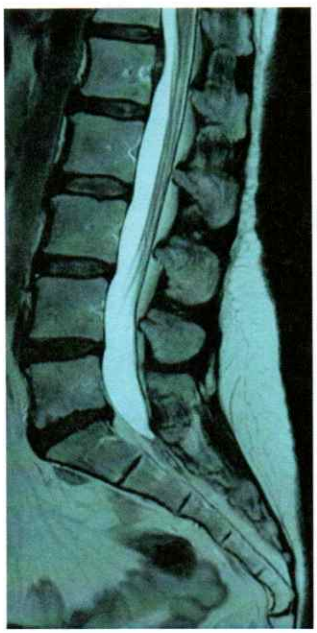
☐ Myelopathy M51.04 ☐ Multiple Sclerosis G35 ☐ Syrinx G95.0

☐ Spinal Stenosis M51.24 ☐ Trauma M54.16 ☐ Other_____

L SPINE (with contrast? ☐) _____

☐ Radiculopathy M54.16 ☐ Spinal Stenosis M48.06 ☐ Postop T88.9XXS

☐ Trauma M54.5 ☐ Tumor C72.0 ☐ Other_____



MR NEUROGRAM: _____

☐ Knee Region M25.569 ☐ Sacral Plexus G54.1 ☐ Brachial Plexus G54.0

☐ Elbow Region G56.20 ☐ Carpal Tunnel G56.00 ☐ Other_____

MR ANGIO: _____

☐ Cranial MRA ☐ Cervical MRA ☐ Cranial MRV

Aneurysm=I67.1 AVM=Q28.2

MR ORTHO: _____

☐ Elbow Joint M25.529 ☐ Pelvic Survey R10.2 ☐ Hip Joint M25.859

☐ Knee Joint M25.569 ☐ Foot M25.579 ☐ Shoulder M25.519

(Please see other side)

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Step 2: If IV Contrast (if none, please skip to Step 3)

☐ Age over 60? ☐ Renal Disease? ☐ Blood Disorder?

☐ Diabetes? ☐ Hepatic Disease? ☐ History of Hypertension?

If so, please arrange for serum creatinine level to be measured within 6 weeks of scan.

Date Test Done:_____Creatinine:_____GFR:_____

_____ cc. Magnevist	_____ cc. Multihance
(For Technician Use)	

Step 3: Safety Screening (please check here ☐ if none apply)

☐ Pacemaker? ☐ Implanted Devices? ☐ Shrapnel/retained metal? ☐ Prior contrast rx?

☐ Aneurysm Clips? ☐ Over 300 lbs? ☐ Claustrophobia? ☐ Possibly pregnant?

Step 4: Clinical History:

STAT reading? ☐

Step 5: Signature

Physician Signature: _____ Print Name: _____ Date: _____

Office Location: _____ Phone: _____ Fax: _____

Step 6: Authorization

Please fax copy of insurance card and pre-auth. document for this MRI to 425-284-1158

Insurance Name: _____

ID#: _____

Authorization Number: _____

CPT Code: _____ Obtained By: _____

☐ Benefits/Eligibility verified on: _____

Coinsurance: _____

Deductible: _____

OOP Max: _____