BLACK HILLS IMAGING CENTER
Proudly owned by physicians

Imaging Request Form

Scheduling (605) 721-4805
Medical Records (605) 721-4969
Scheduling and Pre-Authorization Fax (605) 721-4826

PATIENT INFORMATION

Patient Name _____ DOB ____/____/__ Sex ____ Appointment Time/Date_____/_____

Home Phone _____ Cell/Work Phone_____ Authorization # _____

***Please list previous treatment, testing and/or imaging to why this exam has been ordered:** _____

_____

_____

Request for comparison study? ☐ Y ☐ N Location of study _____

MRI Contra-Indications (If any apply please call before scheduling):

☐ **Pregnancy** ☐ **Claustrophobia** (possible sedation) ☐ **Aneurysm Clips** ☐ **Programmable magnetic shunts**
☐ **Pacemaker/Defibrillator** *(Applies to CT as well)* ☐ **Prior surgery of area** ☐ **Possible metal in eyes** (i.e. welding, grinding, sheet metal work, accident)

EXAMINATION INFORMATION

☐ **Routine** (24 hrs) ☐ **Stat** (6-8 hrs) ☐ **Call Report/Wet Read – Phone** _____ **Best time to call** _____
☐ **CD** — ☐ **Send with patient** ☐ **Send to physician** (address/fax) _____

Creatinine within 28 days may be required when ordering contrast exam for patients with diabetes, transplants and renal dysfunction.

Modality Options: ☐ **Either MRI** ☐ **3T MRI (GE)** ☐ **1T MRI (Siemens)** ☐ **64-Slice CT**

Contrast Options: ☐ **No Contrast** ☐ **With Contrast** ☐ **With & W/out Contrast** ☐ **Radiologist's Discretion**

MRI NEURO
- ☐ Brain
- ☐ IACs
- ☐ Pituitary
- ☐ Orbits
- ☐ Soft tissue neck
- ☐ Brachial plexus
- ☐ C-Spine
- ☐ T-Spine
- ☐ L-Spine
- ☐ L-Spine (post surgery—w/ & w/out con)
- ☐ Sacrum
- ☐ Coccyx
- ☐ Other _____

MRI ORTHO

	L	R
☐ Shoulder	☐	☐
☐ Humerus	☐	☐
☐ Elbow	☐	☐
☐ Forearm	☐	☐
☐ Wrist	☐	☐
☐ Hand	☐	☐
☐ Hip	☐	☐
☐ Thigh/Femur	☐	☐
☐ Knee	☐	☐
☐ Tibia/Fibula	☐	☐
☐ Ankle	☐	☐
☐ Foot	☐	☐

☐ Other _____

MRI OTHER (3T ONLY)
- ☐ MRA Carotid
- ☐ MRA Abdomen
- ☐ MRA Renals
- ☐ MRA Brain (no contrast needed)
- ☐ MRV Brain (no contrast needed)
- ☐ Abdomen
- ☐ Liver
- ☐ Kidney
- ☐ MRCP
- ☐ Pelvis
- ☐ Breast (w & w/out contrast)
- ☐ Other _____

CT
- ☐ Brain
- ☐ IACs
- ☐ Orbits
- ☐ Facial Bones
- ☐ Mastoids
- ☐ TMJ
- ☐ Sinus
- ☐ Soft tissue neck
- ☐ Chest
- ☐ Abdomen
- ☐ Urogram (w/ & w/out contrast)
- ☐ Pelvis
- ☐ C-Spine
- ☐ T-Spine
- ☐ L-Spine
- ☐ Spine intrathecal ☐ C ☐ T ☐ L
- ☐ Extremity (Area of interest) _____
- ☐ Lung
- ☐ Cardiac/Calcium ScoreScreen
- ☐ Bone Mineral Density
- ☐ Other _____

CT ANGIOGRAPHY (All studies w/ contrast)
- ☐ Circle of Willis
- ☐ Carotids
- ☐ Thoracic Aorta
- ☐ Pulmonary Arteries (for PE)
- ☐ Kidneys
- ☐ Abdominal Aorta
- ☐ Lower extremity runoff
- ☐ CCTA
- ☐ Other _____

PHYSICIAN INFORMATION (Required):

Print name _____ **Signature**_____ **Date** _____/_____/_____

Phone _____ **Clinic Name or Address** _____