☐ **SOUTHFIELD CAMPUS**
22401 Foster Winter Drive
Southfield, Michigan 48075
Phone (248) 423-5160
Fax (248) 423- 5165

OAKLAND REGIONAL HOSPITAL

DEPARTMENT OF RADIOLOGY

☐ **WARREN CAMPUS**
11012 Thirteen Mile, Ste. 111
Warren, MI 48093
Phone (586) 558-8470
Fax (586) 558-8481

ALL PATIENTS WHO REQUIRE SEDATION MUST HAVE AN ADULT STAY IN THE BUILDING DURING THE PROCEDURE AND BE ABLE TO DRIVE THE PATIENT HOME.

Please Print

Patient Name	Patient Phone	Date of Birth	Requested Appointment Date & Time
Requesting Physician	**Physician Phone**	**Fax**	**Fax Report** ❑ Yes ❑ No

Symptoms: ❑ Pain ❑ Swelling ❑ Weakness ❑ Loss of Function ❑ Other: _____

_____

Clinical Information:	Previous X-rays or MRI: ❑ Yes ❑ No ❑ Pt to bring ❑ Will Send ❑ At ORH

Physician Signature:	Allergies: ❑ NA ❑ Iodine ❑ Shellfish Other:	Precautions: ❑ NA

Place an (X) or write in the examination(s) requested

Magnetic Resonance Imaging (MRI) - Procedural Requirements

Examination: ❑ MRI ❑ Follow Radiologist's Recommended Protocol ❑ Contrast if Necessary (Please note patient allergies)
❑ Arthrogram ❑ Other: _____

❑ Joint ❑ Right ❑ Left ❑ Bilateral ❑ Finger ❑ Hand ❑ Arm ❑ Wrist ❑ Elbow ❑ Shoulder ❑ Hip ❑ Leg ❑ Knee ❑ Ankle ❑ Foot
Other: _____ ❑ with & without IV contrast ❑ without contrast

❑ Extremity ❑ Right ❑ Left ❑ Bilateral ❑ Finger ❑ Hand ❑ Arm ❑ Wrist ❑ Elbow ❑ Shoulder ❑ Hip ❑ Leg ❑ Knee ❑ Ankle ❑ Foot
Other: _____ ❑ with & without IV contrast ❑ without contrast

❑ Cervical Spine ❑ Thoracic Spine ❑ Lumbar Spine ❑ with & without IV contrast ❑ without contrast

❑ Chest ❑ Abdomen ❑ MRCP ❑ Pelvis ❑ with & without IV contrast ❑ without contrast

❑ Brain ❑ with & without IV contrast ❑ without contrast Check if attention: ❑ Int Aud Canals ❑ Pituitary ❑ Orbits

❑ Soft Tissue ❑ Neck ❑ with & without IV contrast ❑ without contrast

❑ Other: _____ ❑ with & without IV contrast ❑ without contrast

Radiology Exam (X-ray)

❑ Skull ❑ Orbits ❑ Paranasal Sinuses ❑ Cervical Spine ❑ Thoracic Spine ❑ Chest ❑ Abdomen

❑ Joint ❑ Right ❑ Left ❑ Bilateral ❑ Finger ❑ Hand ❑ Arm ❑ Wrist ❑ Elbow ❑ Shoulder ❑ Hip ❑ Leg ❑ Knee ❑ Ankle ❑ Foot
Other: _____

❑ Extremity ❑ Right ❑ Left ❑ Bilateral ❑ Finger ❑ Hand ❑ Arm ❑ Wrist ❑ Elbow ❑ Shoulder ❑ Hip ❑ Leg ❑ Knee ❑ Ankle ❑ Foot
Other: _____

❑ Other _____

Additional Information and/or Request:

Patient Instructions

- **All patients must bring their most recent x-rays, ultrasound reports, and/or films that relate to the current problem.**
- **All tests – Please arrive 30 minutes prior to your scheduled appointment.**