CORE
IMAGING CENTER, LLC

MRI Order

Date _____ / _____ / _____ Referring Physician _____

Patient Name: _____ DOB _____ / _____ / _____

Diagnosis: _____

Physician Signature: _____

*Patient will be X-rayed at our office if history of working with metal.

UPPER EXTREMITIES

____ MRI ANY JOINT UPPER EXTREMITY (WITHOUT CONTRAST)

____ MRI ANY JOINT UPPER EXTREMITY (WITH **AND** WITHOUT CONTRAST)

R/O_____

____ MRI UPPER EXTREMITY OTHER THAN JOINT (WITHOUT CONTRAST)

____ MRI UPPER EXTREMITY OTHER THAN JOINT (WITH **AND** WITHOUT CONTRAST)

R/O_____

LOWER EXTREMITIES

____ MRI ANY LOWER EXTREMITY JOINT (WITHOUT CONTRAST)

____ MRI ANY LOWER EXTREMITY JOINT (WITH **AND** WITHOUT CONTRAST)

R/O_____

____ MRI ANY LOWER EXTREMITY OTHER THAN JOINT, I.E. CALF (WITHOUT CONTRAST)

____ MRI ANY LOWER EXTREMITY OTHER THAN JOINT, I.E. CALF (WITH **AND** WITHOUT CONTRAST)

R/O_____

SPINE

____ MRI CERVICAL SPINE (WITHOUT CONTRAST)

____ MRI CERVICAL SPINE (WITH **AND** WITHOUT CONTRAST)

R/O_____

SPINE (CONT.)

____ MRI THORACIC SPINE (WITHOUT CONTRAST)

____ MRI THORACIC SPINE (WITH **AND** WITHOUT CONTRAST)

R/O_____

____ MRI LUMBAR SPINE (WITHOUT CONTRAST)

____ MRI LUMBAR SPINE (WITH AND WITHOUT CONTRAST)

R/O_____

PELVIS

____ MRI PELVIS (WITHOUT CONTRAST)

____ MRI PELVIS (WITH **AND** WITHOUT CONTRAST)

R/O_____

BRAIN

____ MRI BRAIN WITHOUT CONTRAST

____ MRI BRAIN (WITH **AND** WITHOUT CONTRAST)

R/O_____

OTHER

____ MRA ANGIO HEAD OR NECK (WITHOUT CONTRAST)

____ MRI CHEST WITHOUT CONTRAST

CORE
IMAGING CENTER, LLC

2380 Lakewood Blvd.
Hoffman Estates, IL 60192
Phone: 1-847-690-1776 Ext. 1216

Convenient Monday - Saturday hours.

Wheelchair Accessible