CONTRA COSTA IMAGING CENTER  
Tax ID: 68-0202020

JOHN MUIR MAGNETIC IMAGING CENTER  
Tax ID: 68-0202020

MRI REQUISITION

Scheduling Phone: (925) 952-2701  Scheduling Fax: (925) 941-4065

Date: __________

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<tr>
<th>Patient Name</th>
<th>Last</th>
<th>First</th>
<th>M</th>
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<tr>
<td>Primary Phone</td>
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<td>Clinical History / Symptoms</td>
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<td>Ins. ID#</td>
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<td>Auth. #</td>
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<td>ICD-10 Codes (Required)</td>
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<td>Diagnosis</td>
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<td>Office Contact Person</td>
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<td>Referring Physician (Print Name)</td>
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ANESTHESIA REQUIRED?  Yes  No

CLAUSTROPHOBIC?  Yes  No

IF EXAM NEEDED ON AN EMERGENCY BASIS, PLEASE CALL SCHEDULING (925) 952 - 2701

MRI TABLE WEIGHT LIMITS: JMMC Limit: 550 pounds - CCIC: 550 pounds

Prior related studies  MRI  US  CT  X-RAY  When: __________  Where: __________

SPECIAL IMAGING INSTRUCTIONS:

*IF EXAM NEEDED ON AN EMERGENCY BASIS, PLEASE CALL SCHEDULING (925) 952-2701

IMPORTANT: Please inform us if the patient has a contrast material reaction; life threatening allergic reaction; organ transplant; diabetes; multiple myeloma or kidney disease. Female patients of child-bearing age should inform us if they are, or might be pregnant. Please note if the patient has had a Barium Enema or Upper GI within the past week.

MRI HEAD

- □ Brain
- □ IACs
- □ Orbits
- □ Pituitary/Sella
- □ Other
- □ Stroke Protocol (MRI Brain, MRA Head & Neck)
- □ MRA Head (Circle of Willis)
- □ MRV Brain

MRI BODY

- □ Abdomen (w/o contrast unless w/o specified
  - □ Routine Liver
  - □ Pancreas with MRCP
  - □ MRCP (w/o contrast)
  - □ Renal Mass
  - □ Adrenal
  - □ Eovist Liver
  - □ MRA Abdominal Aorta (including mesenteric arteries)
  - □ MRA Thoracic Aorta
  - □ MRA Renal Artery (hypertension)

- □ Pelvis
  - □ Routine
  - □ Female Pelvis
  - □ Endometrial Cancer Staging
  - □ Rectal CA Protocol
  - □ Prostate
  - □ Anal Fistula
  - □ Scrotum/Phenis
  - □ Other

- □ Chest/Ncek
  - □ Neck (soft tissue)
  - □ Brachial Plexus
  - □ Breast(s)
  - □ Chest/Mediastinum
  - □ MRV of Body Part
  - □ Other

- □ Other

The Radiologist will determine the parameters of the diagnostic test based on patient symptoms and protocols unless the ordering physician has marked this box: [ ] Do not make changes to this order.

EXTREMITY

- □ Arthrogram Injection
  - □ YES  NO
  - □ Shoulder  L  R
  - □ Elbow  L  R
  - □ Wrist  L  R
  - □ Knee  L  R
  - □ Hip  L  R
  - □ Ankle (Hindfoot & Midfoot)  L  R
  - □ Forefoot/Toes  L  R
  - □ Whole foot (do not osteomyelitis only)  L  R
  - □ MRA Peripheral Artery Runoff (includes MRA lower extremity, abdomen, pelvis)  L  R
  - □ Other  L  R

PATIENT COPY

Revised 07/22/2019