MIDWEST OPEN MRI &
MIDWEST IMAGING

Darien	*Melrose Park* **(DBA Midwest Imaging)**	*Elmwood Park*	*Elmhurst*	*North Riverside*
7372 S. Rt. 83(Kingery Hwy)	8319 W. North Ave,	7810 W. North Ave	321 N. York Rd.,	8415 W. Cermak Road
Darien, IL-60561	Melrose Park, IL-60160	Elmwood Park, IL- 60707	Elmhurst, IL-60126	North Riverside, IL-60546
Tele: 630 455 5552	Tele: 708 450 9800	Tele: 708 452 2222	Tele: 630 279 4700	Tele: 708 443 1600
Fax: 630 455 1090	Fax: 708 450 9975	Fax: 708 452 8489	Fax: 630 279 1959	Fax: 708 443 1601

☐ Phone Stat Report ☐ Physician Request Films ☐ Fax Report ☐ Physician Request CD

Patient Name:______________________________ Birthdate:__________

Clinical Information and/or Symptoms:______________________________

MAGNETIC RESONANCE IMAGING (MRI)

HEAD(GEN. STUDY)
- ☐ Brain
- ☐ IAC's
- ☐ Orbits
- ☐ Pituitary
- ☐ Sinuses
- ☐ TMJ ☐ Left ☐ Right
- ☐ Neck (Soft Tissue)

- ☐ Cervical Spine
- ☐ Lumbar Spine
- ☐ Thoracic Spine
- ☐ Chest
- ☐ Abdomen
- ☐ Pelvis
- ☐ Breast ☐ Left ☐ Right

EXTREMITY
- ☐ Left ☐ Right ☐ Bilateral
- ☐ Knee
- ☐ Shoulder
- ☐ Other Joint

Specify:__________

☐ Contrast

Please indicate below if you wish us to use contrast when indicated but not ordered: ☐ Yes ☐ Please call first

ANGIOGRAPHY
- ☐ Circle of Willis
- ☐ Carotids
- ☐ Renals
- ☐ Other:

____

POSITRON EMISSION TOMOGRAPHY (PET)

- ☐ Brain
- ☐ Heart
- ☐ Full Body – Indicate specific area of interest ______________________________

SPIRAL COMPUTED TOMOGRAPHY (CT)

- ☐ Chest
- ☐ Abdomen
- ☐ Pelvis

- ☐ Cervical Spine
- ☐ Lumbar Spine
- ☐ Thoracic Spine
- ☐ Neck (Soft Tissue)

Specify Level:

____

- ☐ Brain
- ☐ Orbits
- ☐ Sinuses
- ☐ Sella/IAC's
- ☐ Facial Bones

- ☐ Non-Contrast
- ☐ Contrast
- ☐ Bun __________
- ☐ Creatinine __________

EXTREMITY

Specify: __________

☐ Left ☐ Right ☐ Bilateral

☐ Contrast

Please indicate below if you wish us to use contrast when indicated but not ordered:

☐ Yes ☐ Please call first

ULTRASOUND

- ☐ Abdomen
- ☐ Liver
- ☐ Gall Bladder
- ☐ Pancreas
- ☐ Other (Specify):

____

- ☐ Renals
- ☐ Spleen
- ☐ Aorta
- ☐ Pelvis

- ☐ OB Complete
- ☐ OB 1stTrimester
- ☐ Thyroid
- ☐ Breast
- ☐ Left ☐ Right

☐ **Transvaginal**

Please indicate below if you wish us to use transvaginal when indicated but not ordered:

☐ Yes ☐ Please call first

Requested by Dr. ____________________ Date:__________ Phone:__________

Address______________________________ Fax:__________

Appointment Day: ______________________________ Time:__________

Physician Signature:______________________________