



**JOHNS HOPKINS**  
M E D I C I N E

THE JOHNS HOPKINS HOSPITAL  
600 NORTH WOLFE STREET  
BALTIMORE, MD 21287

**Department of Radiology**  
**MRI**

STAMP PATIENT'S IDENTIFICATION OR PRINT CLEARLY

Nursing Unit Clinic

Birth Date

J.H.H. History Number

Patient's Name (LAST, FIRST, M.I.)

1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	<input type="checkbox"/> Routine <input type="checkbox"/> Urgent	Scheduled Exam date:	
<input type="checkbox"/> Allergic to Drugs	<input type="checkbox"/> On isolation	LMP	<input type="checkbox"/> Pregnant
Ordering Provider (Print)		Attending Physician (Print)	
Ordering Provider (Signature)		Provider's ID Code	Phone or Beeper
Insurance authorization number if applicable:			

**This exam may require contrast per protocol.**

Please check this box if you DO NOT want your patient to receive MRI contrast  No contrast

Reason for requesting non-contrast \_\_\_\_\_

History of:  dialysis  severe renal failure (Stage 4-5 CKD)  Notify Radiology Scheduler if patient has permanent implanted devices – examples: pacemaker, ICD, programmable shunt or any other foreign objects.

**MRI EXAMINATIONS – (✓) Check Examinations Required**

<input type="checkbox"/> Brain <input type="checkbox"/> Orbits <input type="checkbox"/> Pituitary <input type="checkbox"/> WAND <input type="checkbox"/> Brain MRA <input type="checkbox"/> Aqueductal Stenosis <input type="checkbox"/> Pseudotumor Protocol <input type="checkbox"/> 3 <sup>rd</sup> Ventriculostomy protocol <input type="checkbox"/> Spectroscopy (brain) <input type="checkbox"/> Gamma Knife <input type="checkbox"/> IAC/CPA <input type="checkbox"/> Seizure <input type="checkbox"/> Carotid MRA <input type="checkbox"/> Brain MRV	<input type="checkbox"/> C-Spine <input type="checkbox"/> T-Spine <input type="checkbox"/> L-Spine <input type="checkbox"/> C/T-Spine <input type="checkbox"/> T/L-Spine <input type="checkbox"/> C/T/L-Spine <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Brachial plexus (specify side or bilateral) <input type="checkbox"/> Fetal (specify body part)	<input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis/bladder <input type="checkbox"/> Prostate <input type="checkbox"/> Female Pelvis <input type="checkbox"/> Dynamic Pelvis <input type="checkbox"/> Adrenal <input type="checkbox"/> Liver <input type="checkbox"/> Bile ducts: MRCP <input type="checkbox"/> Chest MRA <input type="checkbox"/> Abdominal/Pelvis MRA <input type="checkbox"/> Peripheral Runoff MRA <input type="checkbox"/> Upper Extremity MRA <input type="checkbox"/> Lower Extremity MRA <input type="checkbox"/> MR venogram (specify body part) <input type="checkbox"/> Cardiac <input type="checkbox"/> Breast (specify implant or tumor evaluation)	<input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT or <input type="checkbox"/> BILATERAL <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Finger <input type="checkbox"/> Hips <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Humerus <input type="checkbox"/> Forearm <input type="checkbox"/> Femur <input type="checkbox"/> Tibia <input type="checkbox"/> Lumbo-Sacral Plexus <input type="checkbox"/> Spectroscopy Specify: _____	<input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT or <input type="checkbox"/> BILATERAL MR Arthrogram: <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Hip Special Instructions:
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OTHER EXAMINATIONS REQUESTED

CLINICAL DX/RELEVANT CLINICAL FINDINGS

ACCESSION CODES	ICD-9 or CPT CODES	EXAM CODES	DEPT CODE	SCHEDULED
				ARRIVED
	PROCEDURE ROOM	TIME IN	TIME OUT	TECHNOLOGIST