Merrimack Valley Hospital
A New Day. A New Vision for the Valley.

140 Lincoln Avenue – Haverhill, MA 01830 – Phone: (978) 374-2000

MRI AND CT IMAGING ORDER FORM

PATIENT NAME: (Last, First, Middle)	Social Security #:	Date of Birth:	Sex: ☐ Male ☐ Female
Ordering Physician Signature: Telephone:	Skilled Nursing Patient: Facility:	☐ Fax results to: ☐ Wet Read	Date:__________________ Time: __________________

PROVIDE DIAGNOSIS/SYMPTOMS FOR ALL TESTS ORDERED:

1) _________________________ **2)** ________________________ **3)** _______________________ **4)** ________________________

MRI	CALL 978-521-8121 TO SCHEDULE	CT SCAN	CALL 978-521-8121 TO SCHEDULE
MRI Contrast ☐ YES ☐ NO	☐ Brain	**CT Contrast** ☐ YES ☐ NO	☐ L or R Shoulder
☐ Abdomen	☐ Orbit / Face / Neck	**BUN result:** ______ **Date of Test:** _____	☐ L or R Arm
☐ Pelvis	**MRA SEQUENCES**	**Creat. Result**_______ **Date of Test:** _______	☐ L or R Elbow
☐ Cervical Spine	☐ Head	☐ Head	☐ L or R Forearm
☐ Thoracic Spine	☐ Neck	☐ Facial	☐ L or R Wrist
☐ Lumbar Spine	☐ Chest	☐ Cervical	☐ L or R Hand
☐ Upper Extremity other than joint RIGHT _____ LEFT ________	☐ Pelvis	☐ Thoracic	☐ L or R Hip
☐ Upper Extremity Joint RIGHT _____ LEFT ________	☐ Upper extremity	☐ Lumbar	☐ L or R Thigh
☐ Shoulder	☐ Lower extremity	☐ Abdomen and Pelvis	☐ L or R Knee
☐ Elbow	☐ Abdomen	☐ Abdomen Only	☐ L or R Ankle
☐ Wrist	☐ Carotid	☐ Pelvis Only	☐ L or R Foot
☐ Lower Extremity other than joint RIGHT _____ LEFT _____	Other:	☐ Chest	☐ CT ANGIOGRAM Specify area: ______________
☐ Lower Extremity Joint RIGHT _____ LEFT _____		☐ Orbits	☐ CCTA
☐ Hip		☐ Sinus	Other:
☐ Knee		☐ Temporal Bones	
☐ Ankle		☐ Neck-Soft Tissue	