

MRI OUTPATIENT REQUEST FORM

Scheduling (432) 221-2300 or Fax Request to (432) 221-4926

- ☐ DIA - Craddick Medical Office Building, 400 Rosalind Redfern Grover Parkway Suite 110 (Located next to MMH)
☐ DIA - Legend's Park Office Building, 5615 Deauville Blvd, Suite 110 (Located near Scarborough Sports Complex)
☐ Abell-Hanger Medical Pavilion, 200 Andrews Highway (Directly South of Midland Memorial)

Appointment Date: _____ Time: _____

Patient Name: _____ D.O.B. _____

Height: _____ Weight: _____ ICD-10-CM Codes: _____ Appropriate Use Score (MRI): _____

Clinical Information: _____

Medical Diagnosis: _____

BODY WITH&WITHOUT CONTRAST

- ☐ Abdomen
☐ Brachial Plexus
☐ Soft Tissue Neck
☐ Thorax
☐ Urogram
☐ Female Pelvis
☐ Male Pelvis/Prostate

BODY WITHOUT CONTRAST

- ☐ MR Cholangiogram
☐ Soft Tissue Pelvis
☐ Other _____

BREAST WITH&WITHOUT CONTRAST

- ☐ Breast Bilateral

CARDIAC WITH&WITHOUT CONTRAST

- ☐ With and Without Contrast

HEAD (Select Contrast Preference)

- ☐ Without Contrast
☐ With and Without Contrast
☐ Routine Brain
☐ Orbits
☐ Pituitary
☐ Temporomandibular Joints (TMJ's)
☐ Internal Auditory Canals (IAC's)
☐ Facial Nerve

LABS ☐ Draw Creatinine GFR: _____**OUTSIDE LAB RESULTS:**

Creatinine: _____ Date Drawn: _____

(Creatinine Range 0.6 – 1.3 mg/dL)

Location Drawn: _____

LOWER EXTREMITY**MUSCULOSKELETAL****(Select Contrast Preference)**

- ☐ Without Contrast
☐ With and Without Contrast
☐ _____ Bony Pelvis* Right Left
☐ _____ SI Joints* Right Left
☐ _____ Hip* Right Left
☐ _____ Femur* Right Left
☐ _____ Knee* Right Left
☐ _____ Tib/Fib* Right Left
☐ _____ Ankle* Right Left
☐ _____ Foot* Right Left
☐ _____ Toe(s)* Right Left
☐ Other _____

*X-rays are required.

MRA WITH CONTRAST

- ☐ Abdomen Aorta
☐ Bilateral Leg Angiogram
☐ MRA Neck – Neurovascular
(includes Arch, Subclavians,
Carotids, Vertebrales)
☐ Renal Arteries
☐ Peripheral Run-Off
☐ Thoracic Aorta
☐ Other _____

MRA WITHOUT**CONTRAST** ☐ MRA Head

Circle of Willis

MRA WITH&WITHOUT CONTRAST

- ☐ MRA/MRV Head

SPINE (Select Contrast Preference)

- ☐ Without Contrast
☐ With Contrast
☐ Cervical*
☐ Thoracic*
☐ Lumbar*
☐ Sacrum/Coccyx*
* X-rays are required.

SEDATION WITH ANESTHESIA

- Provider to fax H & P with order for MRI Exam
- Patient must call (432) 221-4082 to schedule anesthesia assessment prior to day of appointment.
- Arrangements for sedation must be made prior to scheduled appt. time.

UPPER EXTREMITY**MUSCULOSKELETAL****(Select Contrast Preference)**

- ☐ Without Contrast
☐ With and Without Contrast
☐ _____ Shoulder* Right Left
☐ _____ Humerus* Right Left
☐ _____ Forearm* Right Left
☐ _____ Wrist* Right Left
☐ _____ Hand* Right Left
☐ _____ Finger(s)* Right Left
☐ Other _____

*X-rays are required

Medical Provider Signature _____ Date: _____ Time: _____

(This order includes authorization to perform/obtain an orbital x-ray, PRN)

(Patient Label)

Patient Name:

Patient DOB:

MR #:

Acct #:

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MRI

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Effective Date: 06/11/2026

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Midland Memorial Hospital, Midland, Texas 79701
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PATIENT MEDICATIONS: Please bring a list of all over the counter & prescription medications being taken; to include the dose & frequency.

MRI PATIENT PREPS

MRA/MRI Abdomen, MRCP & MRA Lower Extremities: No food or water for eight (8) hours prior to the MRI exam (NPO 8 hours).

MRI Pelvis for rectal tumor and/or staging: 24 hours prior to the MRI exam, consume clear liquids only.

MRI Pelvis Male/Female (Prostate): Two days prior to exam: Eat a light, low residue meal at noon. After this meal clear liquids only. Day prior to exam:

Continue clear liquids and start drinking one glass (8oz minimum) Water every two hours until midnight: The more water the better At 4pm, drink one bottle of Magnesium Citrate At 10pm, take three (3) Dulcolax (Bisacodyl) tablets with one (8oz) glass of water. Day of exam: **Continue drinking only water but nothing to eat.** Two (2) hours before your exam, administer a fleet enema. Medication may be taken with small sips of water.

MRI SAFETY SCREENING

Please answer the questions below. For your safety, you will be asked these questions several times prior to entering the MRI Room. If there is a possibility of metal in your eyes, an x-ray may be necessary prior to the MRI. If you answer "yes" to any of the questions with a *, list the manufacturer, model #, and serial #.

DO YOU HAVE:	YES	NO	If Yes to questions with a *, please provide device manufacturer, model #, and serial #.	DO YOU HAVE:	YES	NO
*Cardiac Pacemaker/Defibrillator	_____	_____		Joint Replacement, Bone Plates/Screws/Rods	_____	_____
*Breast Tissue Expanders	_____	_____		Cardiac Stent(s)	_____	_____
*Cerebral Aneurysm Clip(s) or Coil(s)	_____	_____		Dentures/Retainers/Braces/Partials	_____	_____
*Cerebral Shunt	_____	_____		Metal Removed from the Eyes, if YES by whom?	_____	_____
*Ear/Cochlear Implant(s)	_____	_____		Hearing Aids	_____	_____
*Electronic Implant(s): Insulin pump, pain pump, neuro-stimulator.	_____	_____		Possibility of Pregnancy	_____	_____
*Heart Valve(s)	_____	_____		Radiation/Chemotherapy	_____	_____
*IUD or Other Birth Control Device	_____	_____		Renal Insufficiency, Kidney failure, End Stage Renal Disease or Dialysis?	_____	_____
*Other Stent, Filter, Coil(s)	_____	_____		Surgical Clip(s)	_____	_____
*Prosthesis (Orbital, Limb, Penile)	_____	_____		Tattoo(s) or Tattooed Makeup	_____	_____
*Vascular Aneurysm Clip(s) or Coil(s)	_____	_____		Transdermal(medication) Patch	_____	_____
Abandoned Leads from Cardiac or Other Device(s).	_____	_____		Retained BB, Bullet or Shrapnel in Body.	_____	_____
Breast Implant(s) with RFID micro transponder	_____	_____		Metallic or magnetic cosmetics (e.g nail polish such as "cat eye", eyelashes or contacts)	_____	_____
Do you have other devices and/or foreign body objects that are not listed above?	_____	_____				

(continued next page)

(Patient Label)

Patient Name:

Patient DOB:

MR #:

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Are you Claustrophobic? NOTE: If medication is desired for anxiety, it MUST be provided by your medical provider.	_____	_____	If yes, please rate your claustrophobia on a scale of 1-10 with 10 being extremely claustrophobic. 1 2 3 4 5 6 7 8 9 10
Have you ever experienced a problem related to an MRI Procedure?	_____	_____	If yes, what occurred?
Do you have other devices and/or foreign body objects that are not listed above?	_____	_____	If yes, what?

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