www.molecularscans.com

MOLECULAR SCANS

- ☐ **Bolingbrook**
  215 Remington Blvd.
  MRI, X-Ray, Arthrogram
- ☐ **Chicago**
  4351 N. Cicero Ave.
  High Field MRI, EMG
- ☐ **Hinsdale**
  230 E. Ogden Ave.
  High Field MRI, X-Ray
  Arthrogram, EMG
- ☐ **Wood Dale**
  199 Addison Rd. #107B
  MRI, X-Ray, EMG
- ☐ **Hoffman Estates**
  3200 W. Higgins Rd. Ste. 105
  High Field MRI,
  Arthrogram
- ☐ **Tinley Park**
  7711 W 159th St.
  (By appoinment only)
  High Field MRI,
  CT - Computed Tomography

Once filled out, scan and email a copy of this form to referrals@molecularscans.com
An electronic and fillable version of this form can be found at www.molecularscans.com

P: 630.325.6300 | F: 630.325.6739

Physician Email or Fax #:______________________

Patient's Name:______________________

DOB:__________ Today's Date__________

Patient's Phone #:______________________

Pre-Certification or RQI #______________________

☐ Auto ☐ Workman's Comp. ☐ Personal Injury

*Patients MUST bring valid photo ID, Insurance/Claim #, Attorney/ Adjustor information

☐ Comparison Study:______________________

Location:__________ Date__________

Referring Physician:______________________

Referring Physician Phone:______________________

Notes:

Diagnosis:______________________

☐ Access To Our PACS System ☐ Report Only ☐ Report and CD

EMG

☐ EMG w NCV
☐ Upper Extremity ☐ Lower Extremity
☐ R ☐ L ☐ Bilateral

RADIOLOGY READING

☐ D.P.M Reading ☐ Stat
☐ D.C. Reading
☐ M.D Reading

CT — COMPUTED TOMOGRAPHY

Anatomical CT Imaging:
☐ W ☐ WO ☐ W/WO

Head:
☐ Brain
☐ Facial Bone
☐ Orbits
☐ Sinus
☐ Temporal Bones
☐ **Neck (Soft Tissue)**

Chest:
☐ Routine

Spine:
☐ C-Spine
☐ T-Spine
☐ L-Spine
☐ 3-D Reconstruction

Abdomen/Pelvis:
☐ Abdomen
☐ Pelvis
☐ Abdomen/Pelvis
☐ Stones (Calcifications)

Extremities:
☐ Upper L ___ R ___
☐ Lower L ___ R ___
☐ 3-D Reconstruction

Urography CT Imaging:
☐ Urography

X-RAY

☐ Body Part for X-Ray ______________

R L B

MRI - MAGNETIC IMAGING RESONANCE IMAGING

Is patient claustrophobic?
☐ Yes ☐ No
☐ Requires meds for condition
☐ w ☐ wo ☐ w/wo

Please check the type of study requested

☐ Brain ☐ Thoracic Spine
☐ Pituitary ☐ Lumbar Spine
☐ IACs ☐ Pelvis
☐ Sinus ☐ Orbits
☐ Cervical Spine ☐ Other
☐ Soft Tissue Neck

☐ Shoulder ☐ R ☐ L
☐ Humerus ☐ R ☐ L
☐ Elbow ☐ R ☐ L
☐ Forearm ☐ R ☐ L
☐ Hip ☐ R ☐ L
☐ Femur ☐ R ☐ L
☐ Foot ☐ R ☐ L
☐ Ankle ☐ R ☐ L
☐ Hand ☐ R ☐ L
☐ Wrist ☐ R ☐ L
☐ Knee ☐ R ☐ L
☐ MRA (w/o contrast)
☐ Head

Hinsdale, Hoffman and Chicago Only
☐ Abdomen ☐ Kidney
☐ Liver ☐ Tib/Fib ☐ R ☐ L
☐ Adrenals ☐ Arthrogram

PELVIS

☐ Bony
☐ Female
☐ Male

BRAIN R/O

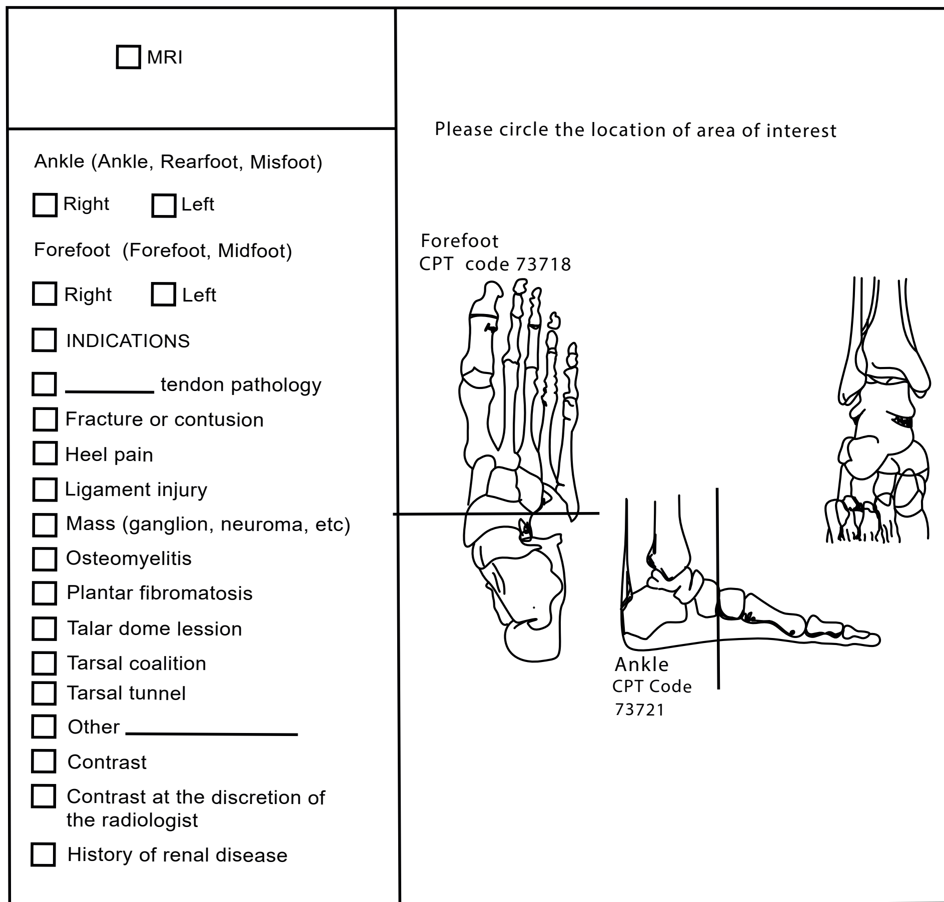
☐ Headache/screening
☐ Stroke (only at Hoffman & Chicago)
☐ MS
☐ Trauma

I hereby authorize Molecular Imaging Companies of locations listed above and/or its designees to provide treatment and/ or examination, release and obtain any provious exams or reports pertinent to my case in the course of my examination or treatment to my physician, insurance company, adjustor or attorney, if applicable in this case

Physician Signature:______________________ Patient Signature:______________________

see back for chiropractic and podiatry detail

MOLECULAR SCANS



☐ MRI

Ankle (Ankle, Rearfoot, Misfoot)

☐ Right ☐ Left

Forefoot (Forefoot, Midfoot)

☐ Right ☐ Left

☐ INDICATIONS

☐ ________ tendon pathology

☐ Fracture or contusion

☐ Heel pain

☐ Ligament injury

☐ Mass (ganglion, neuroma, etc)

☐ Osteomyelitis

☐ Plantar fibromatosis

☐ Talar dome lession

☐ Tarsal coalition

☐ Tarsal tunnel

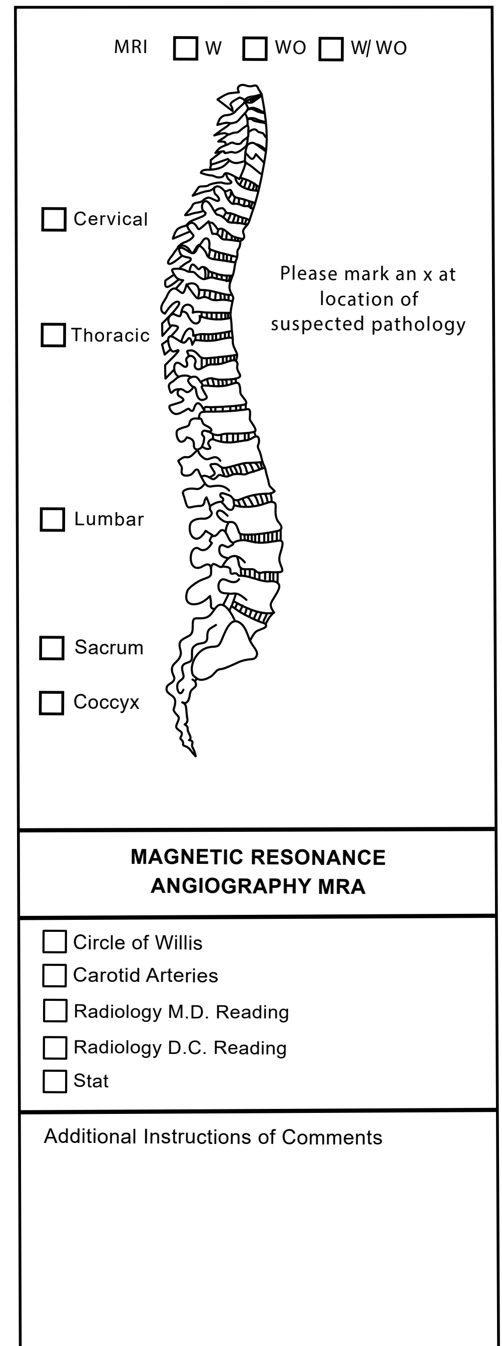
☐ Other ______________

☐ Contrast

☐ Contrast at the discretion of the radiologist

☐ History of renal disease

Please circle the location of area of interest



MRI ☐ W ☐ WO ☐ W/ WO

MAGNETIC RESONANCE ANGIOGRAPHY MRA

☐ Circle of Willis

☐ Carotid Arteries

☐ Radiology M.D. Reading

☐ Radiology D.C. Reading

☐ Stat

Additional Instructions of Comments