

Bolingbrook:
215 Remington Blvd., Suite J
Bolingbrook, Illinois 60440
MRI

Hinsdale:
230 E. Ogden Ave., Suite 100
Hinsdale, Illinois 60521
High Field MRI, X-Ray,
Arthrogram, EMG

Tinley Park:
7711 W. 159th St.
Tinley Park, Illinois 60477
High Field MRI,
CT-Computed Tomography

North Chicago:
1059 N Richmond St
Suite A101
Chicago, Illinois 60622
High Field MRI, CT, X-Ray,
Arthrogram,

South Chicago:
11750 S. Western
Ave
Chicago, Illinois 60643
High Field MRI

Indianapolis:
2060 Shadeland Ave.
Indianapolis, Indiana 46219
High Field MRI, X-Ray



MOLECULAR SCANS

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 | referrals@molecularscans.com | www.molecularscans.com

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 WWO

Head:	Abdomen/Pelvis:
<input type="checkbox"/> Brain	<input type="checkbox"/> Abdomen
<input type="checkbox"/> Facial Bone	<input type="checkbox"/> Pelvis
<input type="checkbox"/> Orbits	<input type="checkbox"/> Abdomen/Pelvis
<input type="checkbox"/> Sinus	<input type="checkbox"/> Stones (Calculifications)
<input type="checkbox"/> Temporal Bones	Extremities:
<input type="checkbox"/> Neck (Soft Tissue)	<input type="checkbox"/> Upper L ___ R ___
Chest:	<input type="checkbox"/> Lower L ___ R ___
<input type="checkbox"/> Routine	<input type="checkbox"/> 3-D Reconstruction
Spine:	Urography CT Imaging:
<input type="checkbox"/> C-Spine	<input type="checkbox"/> Urography
<input type="checkbox"/> T-Spine	
<input type="checkbox"/> L-Spine	
<input type="checkbox"/> 3-D Reconstruction	

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

<input type="checkbox"/> Brain	<input type="checkbox"/> Thoracic Spine
<input type="checkbox"/> Pituitary	<input type="checkbox"/> Lumbar Spine
<input type="checkbox"/> IACs	<input type="checkbox"/> Pelvis
<input type="checkbox"/> Sinus	<input type="checkbox"/> Orbits
<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Other
<input type="checkbox"/> Soft Tissue Neck	
<input type="checkbox"/> Shoulder	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Humerus	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Elbow	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Forearm	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Hip	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Femur	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Foot	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Ankle	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Hand	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Wrist	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Knee	<input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> MRA (w/o contrast)	
<input type="checkbox"/> Head	
Hinsdale, Hoffman and Chicago Only	
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Kidney
<input type="checkbox"/> Liver	<input type="checkbox"/> Tib/Fib <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Adrenals	<input type="checkbox"/> Arthrogram

PELVIS

Bony
 Female
 Male

BRAIN R/O

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

X-RAY

Body Part for X-Ray
R L B

I hereby authorize Molecular Imaging Companies of locations listed above and/or its designees to provide treatment and/ or examination, release and obtain any previous 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

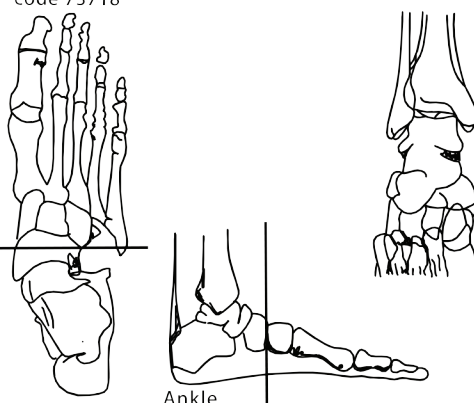
Physician Signature: _____

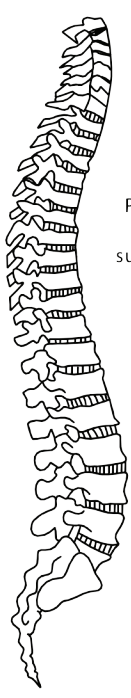
Patient Signature: _____

see back for chiropractic and podiatry detail



MOLECULAR SCANS

<input type="checkbox"/> MRI	Please circle the location of area of interest
Ankle (Ankle, Rearfoot, Misfoot) <input type="checkbox"/> Right <input type="checkbox"/> Left Forefoot (Forefoot, Midfoot) <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> INDICATIONS <input type="checkbox"/> _____ tendon pathology <input type="checkbox"/> Fracture or contusion <input type="checkbox"/> Heel pain <input type="checkbox"/> Ligament injury <input type="checkbox"/> Mass (ganglion, neuroma, etc) <input type="checkbox"/> Osteomyelitis <input type="checkbox"/> Plantar fibromatosis <input type="checkbox"/> Talar dome lesion <input type="checkbox"/> Tarsal coalition <input type="checkbox"/> Tarsal tunnel <input type="checkbox"/> Other _____ <input type="checkbox"/> Contrast <input type="checkbox"/> Contrast at the discretion of the radiologist <input type="checkbox"/> History of renal disease	Forefoot CPT code 73718  Ankle CPT Code 73721

MRI <input type="checkbox"/> W <input type="checkbox"/> WO <input type="checkbox"/> W/WO	
<input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacrum <input type="checkbox"/> Coccyx	 Please mark an x at location of suspected pathology
MAGNETIC RESONANCE ANGIOGRAPHY MRA	
<input type="checkbox"/> Circle of Willis <input type="checkbox"/> Carotid Arteries <input type="checkbox"/> Radiology M.D. Reading <input type="checkbox"/> Radiology D.C. Reading <input type="checkbox"/> Stat	
Additional Instructions or Comments	