



Florence MRI & Imaging

805 S. Irby Street, Florence, SC 29501

Phone: 843.292.0400 | Fax: 843.292.0470 | Tax ID: 571013875

florencemri.com

Patient's name: _____ Date of birth: _____ Call to schedule? ☐ Y ☐ N
Mobile #: _____ Alternate #: _____ Insurance: _____ Clinicals attached? ☐ Y ☐ N
Appointment date: _____ Appointment time: _____ Authorization #: _____

MRI	CT	Ultrasound	X-ray
CONTRAST <input type="checkbox"/> Radiologist discretion (recommended) <input type="checkbox"/> W/O <input type="checkbox"/> W/ & W/O	CONTRAST <input type="checkbox"/> Radiologist discretion (recommended) <input type="checkbox"/> W/ <input type="checkbox"/> W/O <input type="checkbox"/> W/ & W/O	<input type="checkbox"/> Abdomen complete (organs above umbilicus) <input type="checkbox"/> Right upper quadrant (liver, gallbladder, rt. kidney, pancreas) <input type="checkbox"/> Left upper quadrant (spleen, lt. kidney) <input type="checkbox"/> Pelvis (female only) <input type="checkbox"/> Transabdominal <input type="checkbox"/> Transvaginal <input type="checkbox"/> Radiologist discretion <input type="checkbox"/> Renal (kidneys & bladder) <input type="checkbox"/> Aorta <input type="checkbox"/> Thyroid <input type="checkbox"/> Scrotum <input type="checkbox"/> Groin <input type="checkbox"/> Soft tissue Location: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Chest <input type="checkbox"/> KUB <input type="checkbox"/> Abd-supine & upright <input type="checkbox"/> Abd series (incl. PA CXR) <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Pelvis <input type="checkbox"/> Ribs Rt Lt <input type="checkbox"/> Hip Rt Lt <input type="checkbox"/> Shoulder Rt Lt <input type="checkbox"/> Wrist Rt Lt <input type="checkbox"/> Hand Rt Lt <input type="checkbox"/> Knee Rt Lt <input type="checkbox"/> Ankle Rt Lt <input type="checkbox"/> Foot Rt Lt <input type="checkbox"/> Other: _____
<input type="checkbox"/> Brain <input type="checkbox"/> Brain IACs <input type="checkbox"/> Brain pituitary <input type="checkbox"/> Brain & orbits <input type="checkbox"/> TMJ <input type="checkbox"/> Soft tissue neck <input type="checkbox"/> Cervical spine <input type="checkbox"/> Thoracic spine <input type="checkbox"/> Lumbar spine <input type="checkbox"/> Sacrum <input type="checkbox"/> Shoulder Rt Lt <input type="checkbox"/> Elbow Rt Lt <input type="checkbox"/> Wrist Rt Lt <input type="checkbox"/> Hand Rt Lt <input type="checkbox"/> Hip Rt Lt <input type="checkbox"/> Knee Rt Lt <input type="checkbox"/> Ankle/Hindfoot Rt Lt <input type="checkbox"/> Midfoot/Forefoot Rt Lt <input type="checkbox"/> Abdomen <input type="checkbox"/> MRCP <input type="checkbox"/> Pelvis <input type="checkbox"/> Other: _____	<input type="checkbox"/> Orbits <input type="checkbox"/> Head <input type="checkbox"/> Paranasal sinus <input type="checkbox"/> Paranasal sinus stereotactic <input type="checkbox"/> Stealth/Brainlab <input type="checkbox"/> Fusion <input type="checkbox"/> Temporal bones/IAC <input type="checkbox"/> Facial bones <input type="checkbox"/> Soft tissue neck (all with) <input type="checkbox"/> Extremity Rt Lt Location: _____ <input type="checkbox"/> Chest <input type="checkbox"/> High resolution <input type="checkbox"/> PE protocol <input type="checkbox"/> Cardiac score <input type="checkbox"/> Abdomen and pelvis <input type="checkbox"/> Stone protocol (all w/o) <input type="checkbox"/> Abdomen (only) <input type="checkbox"/> Pelvic (only) <input type="checkbox"/> Dedicated studies (all w & w/o) <input type="checkbox"/> Adrenal <input type="checkbox"/> Pancreas <input type="checkbox"/> Liver <input type="checkbox"/> Renal <input type="checkbox"/> C-Spine <input type="checkbox"/> L-Spine <input type="checkbox"/> T-Spine <input type="checkbox"/> CTA of: _____ <input type="checkbox"/> Other: _____ Advanced imaging <input type="checkbox"/> 3D reconstruction	Vascular <input type="checkbox"/> Carotid doppler <input type="checkbox"/> Lower venous doppler Rt Lt Bil <input type="checkbox"/> Upper venous doppler Rt Lt Bil Implant <input type="checkbox"/> Pacemaker (no MRI) <input type="checkbox"/> Neurostimulator <input type="checkbox"/> Make: _____ <input type="checkbox"/> Model: _____	Report delivery Please call when scheduling all STAT exams <input type="checkbox"/> STAT Fax Fax #: _____ <input type="checkbox"/> Call report Cell or backline #: _____ Standard report in 24-48 hours. Comparison studies <input type="checkbox"/> Location: _____

Insurance (Please fax front and back of patient's card and any clinical information to 843.292.0470.)

Clinical indications/signs/symptoms (required): _____

ICD-10 Code(s) (required): _____

Provider name (printed): _____ Provider signature: _____

Office phone: _____ Fax: _____ Date: _____

Carefully follow exam preparation instructions on the back of this form.

Patient instructions

Bring this order to your scheduled exam.

Visit www.florencemri.com for directions and more about our facility and services.

Center information



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CT (Computed Tomography)

Our office will contact you 24 hours before your appointment to confirm and provide instructions.

Oral prep

- You may be given a barium sulfate suspension to drink before your CT scan.
- This is not a laxative. It will enhance your digestive tract so the radiologist can better visualize your anatomy during the scan.
- If eating prior to exam, please eat only a light meal or snack.
- If you have ever had a reaction to X-ray dye, please let us know. Call us at 843.292.0400 prior to your exam.

Ultrasound

Our office will contact you 24 hours before your appointment to confirm and provide instructions.

Orders and patient records

Efficiently manage your patient referrals and related documents with our secure tools. Easily send us copies of referrals, insurance/identification cards, implant information, and more by scanning the QR code or visiting our website:

prf.mqimaging.com/MedQuest/UploadDocFormFlorence



Through our partnership with Clearpath, patients can receive, store, and share medical records and images. Scan the code or go online to initiate Clearpath.

prod.myclarpath.com/login



Let us know if you have:

- Any type of glucose monitoring device (MRI, CT and X-ray)
- Metallic fragments in your eyes or previous injury to the eye involving a metal object
- Any type of implanted mechanical pump
- Any type of surgery within the past 8 weeks
- A history of cancer
- A pacemaker, defibrillator, or stimulator
- An aneurysm clip
- Any metallic or electronic implant

Let us know if you are:

- Allergic to CT or MRI contrast
- Claustrophobic or anxious (If you are, mild sedation may help. Consider discussing options with your provider prior to the test.)
- Pregnant or nursing
- In need of special assistance

MRI (Magnetic Resonance Imaging)

Our office will contact you 24 hours before your appointment to confirm and provide instructions.

Do not wear eye makeup or mascara for ANY brain or neck studies. For all studies, do not wear any jewelry or hairpins. Wear comfortable clothing.