mid-michigan mri inc.
Michigan State University and Sparrow Hospital

MSU Clinical Center, Ste D100 (D-Wing)
840 Service Rd, East Lansing, MI 48824

CT Referral Form

Ph 517-432-8808 (Ext 1)
Fax 517-432-4394
www.rad.msu.edu

Tax ID 382852340
NPI 1023061355

Patient Name _____ DOB _____ Phone _____

Diagnosis/ICD Code(s) _____

Reason for Test or Referral/Signs & Symptoms _____

Injury Date _____ ☐ Male ☐ Female Weight _____

Insurance Type(s) _____ Precertification Number _____

Please Fax Referral Form with insurance Card(s)—front and back

COMPUTERIZED TOMOGRAPHY (CT)

Head
- ☐ Head/Brain
- ☐ Maxillofacial (Sinuses or Face)
- ☐ Orbits/IAC/Pituitary
- ☐ TMJ (Temporo-Mandibular Joint)
- ☐ Dental CT (Implants)

Spine
- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar (LS/Lumbo Sacral)

Upper Extremities & Joints
- ☐L ☐R Shoulder
- ☐L ☐R Scapula
- ☐L ☐R Upper Arm (Humerus)
- ☐L ☐R Elbow
- ☐L ☐R Lower Arm (Radius/Ulna)
- ☐L ☐R Wrist
- ☐L ☐R Hand

Lower Extremities & Joints
- ☐L ☐R Hip
- ☐L ☐R Upper Leg (Femur)
- ☐L ☐R Knee
- ☐L ☐R Lower Leg (Tibia/Fibula)
- ☐L ☐R Ankle (Includes Achilles)
- ☐L ☐R Foot

PRE-SCREENING

Please answer the following questions to assist with scheduling.

Allergy to Contrast or Iodine	☐ YES	☐ NO
Asthma	☐ YES	☐ NO
Kidney Problems	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO
Pregnant	☐ YES	☐ NO

CT ANGIOGRAPHY (CTA)
- ☐ Head Angiography (Cerebral)
- ☐ Neck Angiography (Carotid & Vertebral)
- ☐ Upper Extremity Angiography
- ☐ Chest Angiography
- ☐ Cardiac Angiography
- ☐ Abdomen Angiography
- ☐ Pelvis Angiography
- ☐ Lower Extremity Angiography

CT MYELOGRAM
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Complete Spine

MISCELLANEOUS
- ☐ Neck (Soft Tissue)
- ☐L ☐R Brachial Plexus
- ☐ Chest
- ☐ Heart Screen
- ☐ Abdomen
- ☐ Pelvis
- ☐ CT Colonography
- ☐ Other _____

CT exams with and/or without contrast will be performed per Radiologist's protocol. If you would NOT like contrast administered, check this box: ☐

Referring Physician/Provider Information

Signature or stamp X _____ Form filled out by _____

Printed Name _____ Office Phone _____

Office Fax _____

Print, Sign & Fax

END OF FORM