



# MIDWEST OPEN MRI & MIDWEST IMAGING

## Darien

7372 S. Rt. 83(Kingery Hwy)  
Darien, IL-60561  
Tele: 630 455 5552  
Fax: 630 455 1090

## Melrose Park

**(DBA Midwest Imaging)**  
8319 W. North Ave,  
Melrose Park, IL-60160  
Tele: 708 450 9800  
Fax: 708 450 9975

## Elmwood Park

7810 W. North Ave  
Elmwood Park, IL- 60707  
Tele: 708 452 2222  
Fax: 708 452 8489

## Elmhurst

321 N. York Rd.,  
Elmhurst, IL-60126  
Tele: 630 279 4700  
Fax: 630 279 1959

## North Riverside

8415 W. Cermak Road  
North Riverside, IL-60546  
Tele: 708 443 1600  
Fax: 708 443 1601

Phone Stat Report       Physician Request Films       Fax Report       Physician Request CD

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Clinical Information and/or Symptoms: \_\_\_\_\_

### MAGNETIC RESONANCE IMAGING (MRI)

#### HEAD(GEN. STUDY)

- Brain
- IAC's
- Orbits
- Pituitary
- Sinuses
- TMJ     Left     Right
- Neck (Soft Tissue)

- Cervical Spine
- Lumbar Spine
- Thoracic Spine
- Chest
- Abdomen
- Pelvis
- Breast     Left     Right

#### EXTREMITY

- Left     Right     Bilateral
- Knee
- Shoulder
- Other Joint
- Specify: \_\_\_\_\_
- Contrast

#### ANGIOGRAPHY

- Circle of Willis
- Carotids
- Renals
- Other: \_\_\_\_\_

Please indicate below if you wish us to use contrast when indicated but not ordered:  Yes     Please call first

### POSITRON EMISSION TOMOGRAPHY (PET)

- Brain
- Heart
- Full Body – Indicate specific area of interest \_\_\_\_\_

### SPIRAL COMPUTED TOMOGRAPHY (CT)

- Chest
- Abdomen
- Pelvis
- Cervical Spine
- Lumbar Spine
- Thoracic Spine
- Neck (Soft Tissue)

Specify Level: \_\_\_\_\_

- Brain
- Orbits
- Sinuses
- Sella/IAC's
- Facial Bones
- Non-Contrast
- Contrast
- Bun \_\_\_\_\_
- Creatinine \_\_\_\_\_

#### EXTREMITY

Specify: \_\_\_\_\_

- Left     Right     Bilateral

Contrast  
Please indicate below if you wish us to use contrast when indicated but not ordered:  
 Yes     Please call first

### ULTRASOUND

- Abdomen
- Liver
- Gall Bladder
- Pancreas
- Other (Specify): \_\_\_\_\_

- Renals
- Spleen
- Aorta
- Pelvis

- OB Complete
- OB 1st Trimester
- Thyroid
- Breast
- Left     Right

#### Transvaginal

Please indicate below if you wish us to use transvaginal when indicated but not ordered:  
 Yes     Please call first

Requested by Dr. \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

Address \_\_\_\_\_ Fax: \_\_\_\_\_

Appointment Day: \_\_\_\_\_ Time: \_\_\_\_\_

Physician Signature: \_\_\_\_\_