Cardiovascular MR Exam Referral Form

The Miriam Hospital
Appointments: (401) 793-4448
Fax: (401) 793-4447

Rhode Island Hospital
Appointments: (401) 444-4881
Fax: (401) 444-5732

After completing this form please fax. We will finalize and confirm the appointment date and time with your patient after receiving this referral form.

Patient Name: ____ (M/F)____ DOB: ________________
Address:____
Patient Phone: Home __________________________________ Work _______________________________
Primary Insurance Name and Number: ____
Secondary Insurance Name and Number: ____
Does Patient Speak English: _______ If Not, What Language (for interpreter) ___________________________
Today's Date:____________________________
Exam Date: _______Urgent (please call) _______within 2-3 days
_______ within 1 week _______within < 3 weeks (preferred)
Ordering Physician (Print & Signature): ____
Indication for Scan (Pls include ICD-9): ____
Person Completing this Request (Print): ____
Phone/Pager: _____________________ Back Line: ____________________ Office Fax: ______________
Additional information (*optional; You may fax appropriate notes or prior studies*) _______________________
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Contraindication Screening

Absolute:

- Cardiac pacemaker/Defibrillator/cochlear implant
- Cerebral aneurysm clips (some OK)

Relative (must review with patient):

- Known or possible pregnancy
- Other implanted electrodes, pumps, or electronic devices
- Claustrophobia (consider providing meds)
- Exposure at any time to welding, grinding, sheet metal machines (through work or hobby)
- Other known or possible metal fragments in eyes, head or body
- Weight 350 pounds or more refer to RIH.

Orbit x-rays will be done where indicated

If yes to any of below questions, need creatinine level drawn within prior 30 days

YES	NO	
( )	( )	Known or suspected renal disease
( )	( )	Diabetes
( )	( )	Liver transplant recipient
( )	( )	Hypertension
( )	( )	Age over 60

Examination(s) Desired (*check all that apply*):

MRI of Heart:

With contrast

___**Function & Viability [for cardiomyopathies]** (CPT 75561)
___**Function & Viability with Stress Perfusion (Regadenoson)** (CPT 75563)
___**Function, Viability, & Flow Quantification for Valves** (CPT 75561, 75565)
___**R/o ARVC** (CPT 75561)
___**Congenital Heart Disease [includes MRA & Flow Quant. for Valves, Shunts, etc.]** (75561, 75565, 71555)
___**Cardiac Mass/Tumor** (CPT 75561)
___**Pericardial Disease** (CPT 75561)

Without contrast

___**Function alone** (CPT 75557)
___**Function & Flow Quantification** (CPT 75561, 75565)

MR Angiography (MRA):

___**Pulmonary Vein Mapping** (CPT 71555)
___**MRA of Chest** (CPT 71555)
___**MRA Aorta w/Aortic Valve** (CPT 71555, 75565)
___**MRA of Abdominal Aorta** (CPT 74185)

Other (Specify) ____________________________________

(Referral forms may be downloaded at www.Lifespan.org)