



**Arkansas Children's Hospital
MRI Pre Scheduling Form**

*****FAX form to MRI at (501) 364-3549*****

Patient Name: _____

Medical Record Number: _____ Date of Birth: _____

Parent/Guardian's Daytime Phone: _____ Evening Phone: _____

Parent/Guardian's Name: _____

Physician Name: _____ Date: _____

Phone Number: _____ Fax Number: _____

Date Needed: _____ Contact Person: _____

WHAT EXAM IS BEING ORDERED?

BE SPECIFIC as to what part of the body is being examined i.e. MRI entire spine

**If ordering extremity please specify RIGHT, LEFT or BILATERAL
Also include if you need an arthrogram**

Diagnosis and Clinical History including symptoms:

Sedation is managed by the Radiology Department unless the following information is known:

General Anesthesia Yes No
Sedation Service Yes No

DO NOT WRITE BELOW THIS LINE

The following information will be provided by the MRI staff and faxed back to the referring M.D. so the family can be notified about their appointment date and time.

Exam date and time: _____

Be here at: _____

No solids after: _____

Clear liquids until: _____

ACH MRI Phone Number: 501-364-3510



INTAKE . REF . MRI

