For prior authorization, call or fax:
P 978.250.1866 • F 978.256.9536

If faxing an order, include:
Demographics • Insurance card • Clinical notes

DIAGNOSTIC IMAGING®

Chiropractic Order Form

❍ **Chelmsford:** **P** 978.250.1866 **F** 978.256.9536
❍ **Dedham:** **P** 781.329.0600 **F** 781.329.1713
❍ **Haverhill:** **P** 978.469.0400 **F** 978.469.0408
❍ **Peabody:** **P** 978.818.6272 **F** 978.818.6282
❍ **Springfield:** **P** 413.781.9000 **F** 413.781.7988
❍ **Woburn:** **P** 781.932.8650 **F** 781.932.8619

Appointment date and time	❍ DACBR read ❍ Obtain authorization ❍ Schedule patient	
Patient name (as shown on insurance card)	Cell phone	Home phone
Patient DOB / Insurance		Insurance ID #
❍ Workers' comp ❍ Auto	Date of injury	Authorization #

(REQUIRED) Written Diagnosis/Reason/Symptom for Exam(s). Must include **specific** clinical indications (such as location, context and severity) to support medical necessity for each test.

Is the exam/procedure related to an injury? ❍ No ❍ Yes **If yes,** ❍ Initial, ❍ Subsequent or ❍ Sequela

MRI

❍ **Without contrast** ❍ **With contrast** ❍ **With/Without contrast** ❍ **IV contrast as clinically indicated by radiologist**

NEURO

Brain
- ❍ Brain volumetric imaging (NeuroQuant®)

Spine
- ❍ Cervical
- ❍ Thoracic
- ❍ Lumbar
- ❍ Lumbosacral plexus (includes piriformis)
- ❍ Sacrum and sacroiliac joints
- ❍ Sacrum to include coccyx
- ❍ Other _____

OTHER

- ❍ Other _____

MUSCULOSKELETAL

- ❍ Joint _____
  - ❍ L ❍ R ❍ BIL
- ❍ Extremity (non-joint) _____
  - ❍ L ❍ R ❍ BIL
- ❍ Other _____

X-RAY

(DEDHAM & SPRINGFIELD ONLY)

Views: _____

- ❍ Cervical
- ❍ Cervical flexion/extension
- ❍ Cervical - Davis w/obliques
- ❍ Thoracic
- ❍ Lumbar
  - ❍ Standing ❍ Recumbent
- ❍ Lumbar w/obliques
- ❍ Lumbar flexion/extension
- ❍ Pelvis
- ❍ Ribs ❍ L ❍ R ❍ BIL

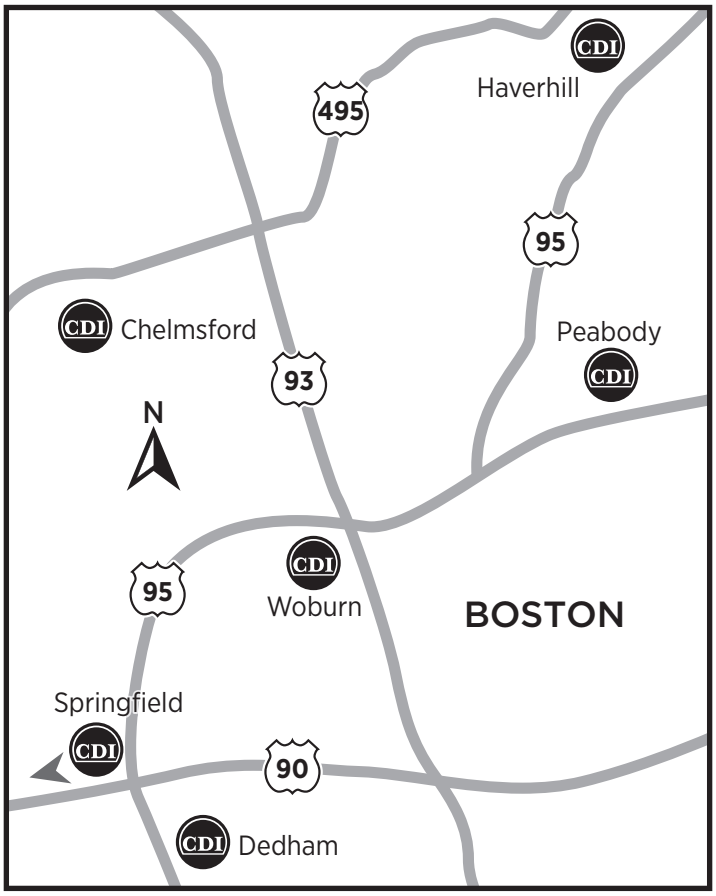
- ❍ Shoulder ❍ L ❍ R ❍ BIL
- ❍ Elbow ❍ L ❍ R ❍ BIL
- ❍ Wrist ❍ L ❍ R ❍ BIL
- ❍ Hand ❍ L ❍ R ❍ BIL
- ❍ Hip ❍ L ❍ R ❍ BIL
- ❍ Knee ❍ L ❍ R ❍ BIL
- ❍ Ankle ❍ L ❍ R ❍ BIL
- ❍ Foot ❍ L ❍ R ❍ BIL
- ❍ X-ray to rule out metal
- ❍ Other _____

REPORTING METHOD: ❍ CD w/Report ❍ Report Only ❍ PT to Carry Films/CD ❍ Portal/Web Viewing ❍ STAT: Call Report ❍ STAT: Fax Report

Report to (Fax/Phone/Address)

Provider name (print)	Phone #	Fax #
Provider signature (required) Do not use rubber stamp.	**NPI # (required)**	Date

DIAGNOSTIC IMAGING®



CENTER	PHONE	FAX	ADDRESS	MRI	OPEN MRI	THERAPEUTIC INJECTIONS	X-RAY	ARTHRO
Chelmsford	978.250.1866	978.256.9536	187 Billerica Rd., Chelmsford, MA 01824	●	●			
Dedham	781.329.0600	781.329.1713	200 Providence Hwy., Suite 210, Dedham, MA 02026	●	●	●	●	●
Haverhill	978.469.0400	978.469.0408	One Park Way, Haverhill, MA 01830	●				
Peabody[1]	978.818.6272	978.818.6282	One Orthopedics Dr., Peabody, MA 01960	●				●
Springfield	413.781.9000	413.781.7988	3640 Main St., Suite 101, Springfield, MA 01107	*3T MRI, High-field open MRI, CT, Ultrasound, X-ray, Arthrography*				
Woburn	781.932.8650	781.932.8619	800 W. Cummings Park, Suite 1150, Woburn, MA 01801		●			

[1]Peabody Imaging North NPI 1760423719/TIN 04-3205435

Magnetic Resonance (MRI) Procedures

Currently, there are no known biological hazards from MRI; however, since the technique involves strong magnetic fields, certain precautions must be taken. For safety reasons, exclusion from MRI examinations includes patients with: cardiac pacemakers, cardio defibrillators (ICD), cochlear ear implants, insulin pumps, severe renal disease, internal ferromagnetic aneurysm clips in the brain, metallic shrapnel or foreign bodies in or near vital structures (e.g. eyes).

Prior to exam, inform the office if you are/may be pregnant.

Contrast Studies

Patients over 60 years of age require a blood test prior to their contrast study.

A serum creatinine is required for patients if:

1. Diabetic
2. Known renal disease
3. Chemotherapy within the last 6 months
4. Renal transplant patient
5. Previous nephrectomy
6. Hypertension requiring medication