



PHYSICIAN ORDER FORM

Patient's Name: _____
 Last First M.I.

D.O.B.: / / _____
 mm dd yyyy Home Phone: _____ Cell Phone: _____

Address: _____
 Street Address City State Zip

Guarantor Email: _____

Insurance/Medicaid Plan: _____ Policy & Group #: _____

Authorization #: _____ **Please also email copy of insurance card front & back with this order**

Reason for Exam:
 (Signs, Symptoms, Chief Complaint): _____

Ordering Physician's Signature: _____ Office Contact: _____
 Practice Phone: _____
 Backline Phone: _____
 Fax: _____
 Physician Name: _____
 Date/Time signed: _____
 PCP Name (if different): _____

SPECIAL INSTRUCTIONS: Schedule for Date/Time:
 Send CD with patient Research Patient
 Order Comments: _____

MRI

MRI Hip without contrast
 3T High Resolution Hip (non-arthrographic) L R MRI Lower Extremity Rotational Profile (Pelvis to Ankle)
 3D Print

MRI Pelvis with/without
 Hip Perthes Profusion Protocol L R Other: Please Specify _____

MUSCULOSKELETAL PROCEDURES

MRI Arthrogram + Injection: Specify Site _____ Tendon Sheath Steroid Injection: Specify Site _____
 Steroid Injection: Specify Site _____ Ganglion Cyst Ultrasound + Fenestration: Specify Site _____
 MRI JIA Protocol + Injection: Specify Site _____

ULTRASOUND

US MSK Shoulder
 Glenohumeral Dysplasia L R US Infant Hips - DDH: with manipulation **OR** without manipulation
 Other - Please Specify _____

CT

CT knee without contrast
 Dynamic knee with low dose with 0, 20, 40 degree flexion CT Version (Rotational Profile) Acetabular Femoral
 CT Tibial Torsion

CT Forearm
 Rotational Profile

Main Campus [in the Texas Medical Center]

Mark A. Wallace Tower 6701 Fannin Street Houston, TX 77030	West Tower 6621 Fannin Street Houston, TX 77030	Pavilion for Women 6651 Main Street Houston, TX 77030	West [Katy] Campus 18200 Katy Freeway Houston, TX 77094	Woodlands Campus 17600 Interstate 45 S The Woodlands, TX 77384
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