

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 #	
<input type="radio"/> Workers' comp <input type="radio"/> 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 \_\_\_\_\_

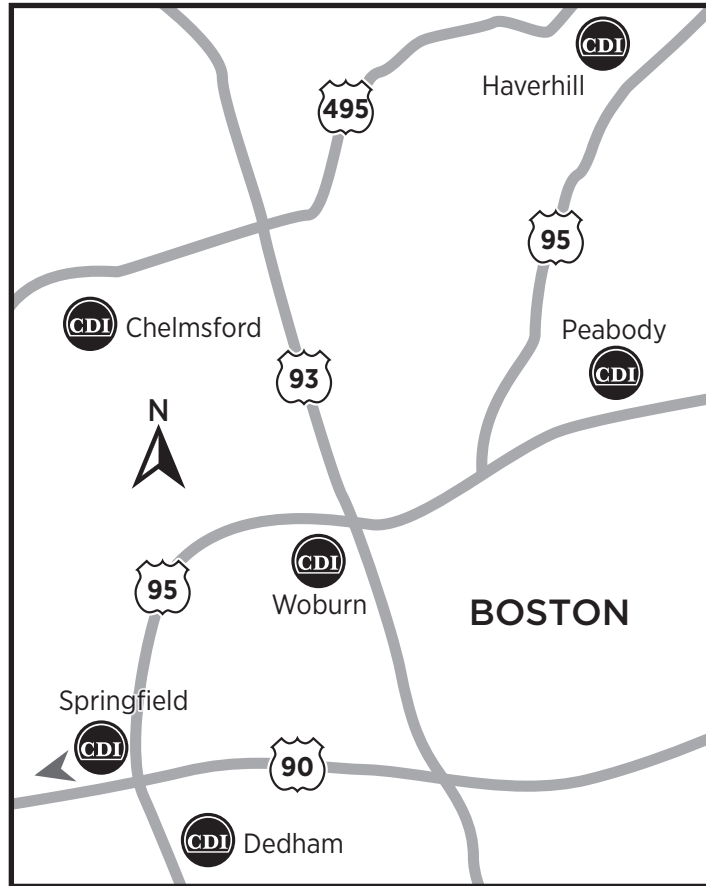
REPORTING METHOD:  CD w/Report  PT to Carry Films/CD  STAT: Call Report  
 Report Only  Portal/Web Viewing  STAT: Fax Report

Report to (Fax/Phone/Address)

Provider name (print)	Phone #	Fax #
Provider signature (required) <i>Do not use rubber stamp.</i>	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 <sup>1</sup>	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		●				

<sup>1</sup>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