



Center for Diagnostic Imaging  
General Order Form for Medical Imaging and Pain Management

This form must be filled out and signed by a medical professional who is legally approved to order your specific medical imaging procedure.

Medica, Blue Cross Blue Shield of Minnesota, and HealthPartners require that any referral for an MRI or CT go through a pre-notification process prior to occurring.

CDI's Three-in-One Scheduling process includes a pre-notification process which is approved by these payers, by which CDI conducts a clinical appropriateness check on your exam.

This provides you and your physician with a more straightforward, streamlined scheduling process.

**REFERRING PROVIDER: Please fill in the information below. This form can be faxed directly to CDI at one of the numbers below.**

Today's Date:		Referring Office Contact:		Phone:	Fax:
Patient Name:		Insurance Name:			
Patient's Home Ph:		Insurance Group/Member #s:			
Patient's Work Ph:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female			
Patient's DOB:     /     /					
<b>REFERRING PHYSICIAN INFORMATION</b>			<b>IMAGING PROVIDER INFORMATION</b>		
Clinic Name:			CENTER FOR DIAGNOSTIC IMAGING (CDI)		
Physician Name:			Phone: 320.251.0609		
Location/Address:			Fax: 320.251.3806		
Phone #:			Preferred CDI Location (check one):		
			<input type="checkbox"/> St. Cloud NorthWest <input type="checkbox"/> St. Cloud South		
			<input type="checkbox"/> Sartell <input type="checkbox"/> Alexandria		

**IMAGING PROCEDURE:**      MRI      CT      X-RAY      ULTRASOUND      MAMMOGRAPHY

BODY PART TO BE STUDIED: \_\_\_\_\_  RIGHT      LEFT      BOTH

Contrast and reconstructions as indicated by the radiologist, or:      No contrast      W & WO contrast      With contrast only  
 With reconstructions      Without reconstructions

**DIAGNOSTIC/THERAPEUTIC PROCEDURE:**      ARTHROGRAM      BURSA INJECTION      DISCOGRAM      EPIDURAL STEROID INJECTION  
 FACET JOINT INJECTION      FACET NERVE INJECTION      MYELOGRAM      NERVE ROOT BLOCK      TRIGGER POINT INJECTION  
 RADIOFREQUENCY (RF) RHIZOTOMY      OTHER: \_\_\_\_\_

BODY PART TO BE STUDIED/TREATED: \_\_\_\_\_  RIGHT      LEFT      BOTH

NOTES: \_\_\_\_\_

**CLINICAL INFORMATION (ALL INFO MUST BE COMPLETED FOR PRE-NOTIFICATION PROCESS AS EXPLAINED ABOVE)**

1. Patient's diagnosis or symptoms (include duration, frequency, and intensity):
2. What is the physician suspecting or ruling out with the requested study?
3. Has the patient received treatment for the above symptoms? (Include duration and type of treatment.)
4. List any previous relevant testing (i.e. labs, diagnostic imaging, or other test), and results:
5. Is this injury related?  Yes  No     If yes, date and type of injury:
6. Is study part of a standard post-chemo/radiation protocol in a patient with a prior cancer diagnosis?  
 Yes  No     If yes, cancer type:

**PHYSICIAN SIGNATURE:**

(REQUIRED)

**Please note:** CDI offers a full range of diagnostic imaging procedures, including MRI, CT, Nuclear Medicine, PET/CT, X-Ray and Ultrasound. This limited order form is meant to assist with orders for the most common medical imaging exams. CDI also offers diagnostic and therapeutic injections to assist with diagnosing and treating back, neck and joint pain. For more information, go to [www.CDIradiology.com](http://www.CDIradiology.com) or call us at one of the numbers above. Thank you.