RESEARCH
Order

DEPARTMENT OF RADIOLOGY AND IMAGING SCIENCES

INDIANA UNIVERSITY
School of Medicine

RESEARCH
Order

Study Name: _____ ORI STUDY ID# _____

Patient Name: _____ MRN: _____

Exam Date: _____ ☐ REPORT ☐ DO NOT REPORT

Exam(s) Requested: _____

Patient History and Reason for Study: _____

Diagnosis w/ ICD-9 Code: _____

Prior Imaging Exams: _____

Special Instructions _____

Printed name of Ordering Physician: _____ Signature of Ordering Physician: _____

How to Bill:

Clinicaltrials.gov Identifier _____

☐ Charge all radiology exams to *patient*

☐ Charge all radiology exams to *grant account*

Grant account # _____

List mixed charges: _____

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Please email orders to orisched@iupui.edu
or fax to 274-8124

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