

Date of Referral: \_\_\_/\_\_\_/\_\_\_

Insurance Provider: \_\_\_\_\_ Authorization #: \_\_\_\_\_

**Multi-position, Open MRI Referral**

**Appointment** Date: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_\_\_ am pm

Patient: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Patient Phone: \_\_\_\_\_ Is patient claustrophobic? No \_\_\_ Yes \_\_\_ (If Yes, Mild \_\_\_ Severe \_\_\_)

Chief complaint(s): \_\_\_\_\_

Surgical history related to this body part: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Physician Signature: \_\_\_\_\_

Physician Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Diagnosis Code: \_\_\_\_\_ Fax: \_\_\_\_\_

**CD REQUESTED:**  Yes  No **REPORT:**  Routine  Urgent  Fax Report  Call Report

**VERY IMPORTANT: If patient has a pacemaker/cardiac defibrillator or any metal objects in their body, or if patient might be pregnant, please notify our practice before patient appointment.**

**HEAD**



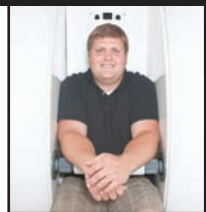
- |  |                              |                                  |
|--|------------------------------|----------------------------------|
| <input type="checkbox"/> Routine Brain | <input type="checkbox"/> w/o | <input type="checkbox"/> w & w/o |
| <input type="checkbox"/> TMJ           | <input type="checkbox"/> w/o | <input type="checkbox"/> w & w/o |
| <input type="checkbox"/> Sinuses       | <input type="checkbox"/> w/o | <input type="checkbox"/> w & w/o |
| <input type="checkbox"/> IAC's         | <input type="checkbox"/> w/o | <input type="checkbox"/> w & w/o |
| <input type="checkbox"/> Pituitary     | <input type="checkbox"/> w/o | <input type="checkbox"/> w & w/o |
| <input type="checkbox"/> Orbits        | <input type="checkbox"/> w/o | <input type="checkbox"/> w & w/o |

**BODY**



- |                                      |                              |                                  |
|--------------------------------------|------------------------------|----------------------------------|
| <input type="checkbox"/> Abdomen     | <input type="checkbox"/> w/o | <input type="checkbox"/> w & w/o |
| <input type="checkbox"/> Pelvis      | <input type="checkbox"/> w/o | <input type="checkbox"/> w & w/o |
| <input type="checkbox"/> Other _____ |                              |                                  |

**UPPER EXTREMITIES**



- |                                      |                            |                            |                              |                                  |
|--------------------------------------|----------------------------|----------------------------|------------------------------|----------------------------------|
| <input type="checkbox"/> Shoulder    | <input type="checkbox"/> L | <input type="checkbox"/> R | <input type="checkbox"/> w/o | <input type="checkbox"/> w & w/o |
| <input type="checkbox"/> Elbow       | <input type="checkbox"/> L | <input type="checkbox"/> R | <input type="checkbox"/> w/o | <input type="checkbox"/> w & w/o |
| <input type="checkbox"/> Wrist       | <input type="checkbox"/> L | <input type="checkbox"/> R | <input type="checkbox"/> w/o | <input type="checkbox"/> w & w/o |
| <input type="checkbox"/> Hand        | <input type="checkbox"/> L | <input type="checkbox"/> R | <input type="checkbox"/> w/o | <input type="checkbox"/> w & w/o |
| <input type="checkbox"/> Other _____ |                            |                            |                              |                                  |

Special Instructions \_\_\_\_\_

**LOWER EXTREMITIES**



- |                                      |                            |                            |                              |                                  |
|--------------------------------------|----------------------------|----------------------------|------------------------------|----------------------------------|
| <input type="checkbox"/> Hip         | <input type="checkbox"/> L | <input type="checkbox"/> R | <input type="checkbox"/> w/o | <input type="checkbox"/> w & w/o |
| <input type="checkbox"/> Knee        | <input type="checkbox"/> L | <input type="checkbox"/> R | <input type="checkbox"/> w/o | <input type="checkbox"/> w & w/o |
| <input type="checkbox"/> Ankle       | <input type="checkbox"/> L | <input type="checkbox"/> R | <input type="checkbox"/> w/o | <input type="checkbox"/> w & w/o |
| <input type="checkbox"/> Foot        | <input type="checkbox"/> L | <input type="checkbox"/> R | <input type="checkbox"/> w/o | <input type="checkbox"/> w & w/o |
| <input type="checkbox"/> Other _____ |                            |                            |                              |                                  |



Special Instructions \_\_\_\_\_

**CERVICAL**



- |                              |                                  |
|------------------------------|----------------------------------|
| <input type="checkbox"/> w/o | <input type="checkbox"/> w & w/o |
|------------------------------|----------------------------------|

**Optional Positions**

- |  |   |
|--|---|
| <input type="checkbox"/> Flexion   | <input type="checkbox"/> Extension  |
|  |  |

**THORACIC**



- |                              |                                  |
|------------------------------|----------------------------------|
| <input type="checkbox"/> w/o | <input type="checkbox"/> w & w/o |
|------------------------------|----------------------------------|



**LUMBAR**



- |                              |                                  |
|------------------------------|----------------------------------|
| <input type="checkbox"/> w/o | <input type="checkbox"/> w & w/o |
|------------------------------|----------------------------------|

- |                                  |                                    |
|----------------------------------|------------------------------------|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Recumbent |
|----------------------------------|------------------------------------|

**Optional Positions**

- |   |   |
|---|---|
| <input type="checkbox"/> Flexion  | <input type="checkbox"/> Extension  |
|  |  |