Multi-position, Open MRI Referral

Date of Referral: ___/___/_____

Insurance Provider: ____________________ Authorization #: ____________________

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

☐ Routine Brain	☐ w/o	☐ w & w/o
☐ TMJ	☐ w/o	☐ w & w/o
☐ Sinuses	☐ w/o	☐ w & w/o
☐ IAC's	☐ w/o	☐ w & w/o
☐ Pituitary	☐ w/o	☐ w & w/o
☐ Orbits	☐ w/o	☐ w & w/o

BODY

☐ Abdomen	☐ w/o	☐ w & w/o
☐ Pelvis	☐ w/o	☐ w & w/o

☐ Other ____________________

UPPER EXTREMITIES

☐ Shoulder	☐ L	☐ R	☐ w/o	☐ w & w/o
☐ Elbow	☐ L	☐ R	☐ w/o	☐ w & w/o
☐ Wrist	☐ L	☐ R	☐ w/o	☐ w & w/o
☐ Hand	☐ L	☐ R	☐ w/o	☐ w & w/o

☐ Other ____________________

Special Instructions ____________________

LOWER EXTREMITIES

☐ Hip	☐ L	☐ R	☐ w/o	☐ w & w/o
☐ Knee	☐ L	☐ R	☐ w/o	☐ w & w/o
☐ Ankle	☐ L	☐ R	☐ w/o	☐ w & w/o
☐ Foot	☐ L	☐ R	☐ w/o	☐ w & w/o

☐ Other ____________________

Special Instructions ____________________

CERVICAL

☐ w/o ☐ w & w/o

Optional Positions

☐ Flexion ☐ Extension

THORACIC

☐ w/o ☐ w & w/o

LUMBAR

☐ w/o ☐ w & w/o

☐ Sitting
☐ Recumbent

Optional Positions

☐ Flexion ☐ Extension