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MEDICAL OFFICES

Please fill out this form completely. Fax the form along with the patient's insurance card(s) front and back for each visit along with clinical notes.

Medical Notes:

1st Date of Service

_____

Last Date of Service

_____

Date of X-Ray

_____

Prior X-Ray Findings & Reports

_____

_____

PLEASE SEND LAST 2 VISITS OF OFFICE VISIT NOTES.

Conservative Treatment:

☐ Outpatient PT

☐ Home PT

☐ Other_____

How Long?_____

Medication(s) Prescribed:

_____

_____

_____

How Long?_____

NSAIDS:

☐ Yes ☐ No

How Long?_____

Patient: _____ **D.O.B.:** _____

Home Phone: _____ **Cell Phone:** _____

Insurance: _____ **Pre-Cert #:** _____ **Exp. Date:** _____

ICD-10: _____ **ICD-10:** _____ **(Must have 2)** **R/O:** _____

Any non MRI compliant devices? ☐ **Yes** ☐ **No** **Is patient claustrophobic?** ☐ **Yes** ☐ **No**

Referring Physician/Nurse Practitioner: _____
(Printed)

Signature: _____

Office Phone #: _____ **Office Fax #:** _____

Additional Notes: _____

MRI Study

PACEMAKER/DEFIBRILLATOR: DO NOT SCHEDULE PATIENT

- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbosacral Spine
- ☐ Sacrum/Coccyx
- ☐ Pelvis: Bony or Organs
- ☐ TMJs
- ☐ Brain: ☐ IAC's ☐ Pituitary ☐ Orbits
- ☐ MRA: ☐ Brain (Arteries Circle of Willis)
  ☐ Neck (Arterial)
- ☐ Other_____
- ☐ Tib/Fib _____
- ☐ Soft Tissue Neck
- ☐ Abdomen:Must pick one
  - ☐ Pancreas
  - ☐ Adrenal
  - ☐ Kidney
- ☐ Hand R / L
- ☐ Forearm R / L
- ☐ Elbow R / L
- ☐ Wrist R / L
- ☐ Knee R / L
- ☐ Humerus R / L
- ☐ Shoulder R / L
- ☐ Foot R / L
- ☐ Hip R / L
- ☐ Thigh/Femur R / L
- ☐ Ankle R / L
- ☐ With & Without Contrast
- ☐ Without

Ultrasound

- ☐ Thyroid
- ☐ MSK Soft Tissue
- ☐ Abdomen - Complete
- ☐ Abdomen - (GB/Liver)
- ☐ Renal Arterial Doppler
- ☐ Renal Only
- ☐ Renal to include bladder
- ☐ Bladder pre/post void
- ☐ Aorta
- ☐ Pelvic - Female Organs Only
- ☐ Transvaginal
- ☐ Scrotal
- ☐ OB - 1st Trimester
- ☐ OB - Limited
- ☐ OB - Complete
- ☐ 2D Echo with CFD
- ☐ Carotid Duplex
- ☐ Lower Ext Venous R / L
- ☐ Lower Ext Arterial R / L
- ☐ Upper Ext Venous R / L
- ☐ Upper Ext Arterial R / L
- ☐ Ankle/Brachial Indices

Catscan

PATIENTS OVER 40 GETTING IODINE NEED BUN/CREATINE WITHIN **LAST 30 DAYS.**

- ☐ Head/Brain
- ☐ Sinuses
- ☐ Facial Bones
- ☐ Soft Tissue Neck
- ☐ Chest
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Upper Extremity
- ☐ Lower Extremity
- ☐ Stone Protocol
- ☐ Abdomen
- ☐ Abdomen including Pelvis
- ☐ Pelvis
- ☐ Angiography:
  - ☐ Head ☐ Neck
  - ☐ Chest ☐ Abdomen w/Pelvis
- ☐ With Iodine
- ☐ Without Iodine
- ☐ With Barium
- ☐ Without Barium