Searcy OPEN MRI

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PHYSICIANS ORDER

Same Day Scheduling/ Results in 24 Hrs
Weekend Appointments
Self Pay Discounts
ACR Accredited

Patient Name:_____ DOB:_____/_____/_____ Wt: _____lbs. _____ht. _____

Patient Address:_____ CITY/ST/ZIP: _____

Patient Contact #: (_____) _____ - _____ Patient Alt. #: (_____) _____ - _____ Male / Female

SS#: _____

Appointment Date: _____ Appointment Time: _____

MRI

CONTRAST: ☐ **YES** ☐ **NO**

Please complete if contrast is ordered:

□ Y □ N Patient over 70 years of age
□ Y □ N Diabetic
□ Y □ N Hypertension
□ Y □ N Renal disease/renal insufficiency
□ Y □ N Severe hepatic disease
□ Y □ N History of liver transplant /or pending

If any are YES, will need GFR (BUN/Creatine) performed within the past 30 days

□ **BRAIN**
- □ WITH ORBITS □ WITH IAC'S
- □ WITH PITUITARY / SELLA

□ CERVICAL SPINE
□ LUMBAR SPINE
□ THORACIC SPINE
□ SACRUM
□ SHOULDER □ R □ L
□ HUMERUS □ R □ L
□ ELBOW □ R □ L
□ WRIST □ R □ L
□ HAND □ R □ L
□ HIP □ R □ L
□ FEMUR □ R □ L
□ LOWER LEG □ R □ L
□ KNEE □ R □ L
□ ANKLE □ R □ L
□ FOOT □ R □ L
□ PELVIS
□ Other_____

□ **MRA**
- □ HEAD wo □ NECK wo

PATIENT HISTORY

Does the patient have a history of any of the following:

☐ PACEMAKER
☐ ANEURYSM CLIPS
☐ CURRENTLY PREGNANT
☐ SURGERY WITHIN THE LAST 6 WEEKS
☐ IMPLANTED DEVICES
☐ IS ORAL SEDATION BEING PRESCRIBED BY M.D. FOR EXAM?

DIAGNOSIS CODE

CD with patient? □ Y □ N

_____ _____

_____ _____

_____ _____

INSURANCE INFORMATION

Primary Ins.:_____

Patient ID#:_____Group#:_____

Pre-Authorization #: _____

Secondary Ins.:_____

Patient ID#:_____Group#:_____

Print Physician Name: _____ Phone #:_____

REFERRING PHYSICIAN SIGNATURE:_____NPI #:_____Date: ____/_____/_____

Based on the patient's history, exam and diagnosis, I have requested the above listed exam(s). I hereby certify that the exam(s) are medically necessary.

☐ STAT Call Report to: (_____) _____ - _____ ☐ FAX Report to: (_____) _____ - _____