



2019 East Race Avenue
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PHYSICIANS ORDER

Same Day Scheduling/ Results in 24 Hrs
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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: (____) _____ - _____