



EXAM: ☐ MRI ☐ MRA ☐ CT ☐ CTA

PATIENT INFORMATION

Date/Time of Exam: _____ Date of Birth: _____

Patient Name: _____

Phone: _____ Work Phone: _____

INSURANCE INFORMATION

Insurance Carrier: _____ Group/Policy: _____

Policy Holder/DOB: _____ Precert#/Exp Date: _____

Name of Authorization Rep: _____

SCAN INFORMATION

Referring Physician: _____ PCP: _____

Physician Phone: _____ Fax: _____

Area to be scanned: _____ Prior Surgery to areas: ☐ YES ☐ NO

PRIOR STUDIES TO AREA BEING SCANNED: ☐ YES ☐ NO / WHERE: _____ WHEN: _____

PRIOR—PLEASE HAVE PATIENT BRING CD OF PRIOR IMAGES ON DAY OF EXAM.

Primary Diagnosis: _____

Signs & Symptoms: _____

(A "rule out" diagnosis may accompany a diagnosis for signs and symptoms but is not acceptable by itself)

If CONTRAST is required: Patients who are over 60, diabetic, or have high blood pressure labs (bun/creat) are required and must be done within 30 days of exam.

WARNING!! AN MRI CANNOT BE PERFORMED IF A PATIENT HAS ANY OF THE FOLLOWING:

Pacemaker or Pacemaker Wires – Defibrillator Device – Cochlear Implant – Small Bowel Endoscopy Capsule

Check if applicable:

☐ Metal in body including eyes ☐ Prior contrast reaction ☐ Claustrophobic ☐ Weighing over 300 lbs.

PHYSICIAN'S SIGNATURE: _____

DATE: _____