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Tax ID # 371701841

Patient Name: ______ DOB: ______
Home Phone: ______ Cell Phone: ______
Health Insurance: ______ Policy#: ______ Group#: ______
Authorization: ______

MRI

HEAD AND BRAIN	w/o	w/	w/& w/out
Brain	❑	❑	❑
Face	❑	❑	❑
IAC	❑	❑	❑
Maxillofacial	❑	❑	❑
Neck Soft Tissue	❑	❑	❑
Orbit	❑	❑	❑
Pituitary	❑	❑	❑
TMJ-Mandible	❑	❑	❑
SPINE			
Cervical	❑	❑	❑
Thoracic	❑	❑	❑
Lumbar	❑	❑	❑
Sacrum/Coccyx	❑	❑	❑
LOWER EXTREMITY			
Ankle R ___ L ___	❑	❑	❑
Foot R ___ L ___	❑	❑	❑
Tibia/Fibula R ___ L ___	❑	❑	❑
Toe R ___ L ___	❑	❑	❑
Heel R ___ L ___	❑	❑	❑
Hip R ___ L ___	❑	❑	❑
Knee R ___ L ___	❑	❑	❑
Femur R ___ L ___	❑	❑	❑
UPPER EXTREMITY			
Elbow R ___ L ___	❑	❑	❑
Finger R ___ L ___	❑	❑	❑
Forearm R ___ L ___	❑	❑	❑
Hand R ___ L ___	❑	❑	❑
Shoulder R ___ L ___	❑	❑	❑
Wrist R ___ L ___	❑	❑	❑
Humerus R ___ L ___	❑	❑	❑
BODY			
Abdomen	❑	❑	❑
Brachial Plexus	❑	❑	❑
MRCP	❑	❑	❑
Pelvis – Soft Tissue	❑	❑	❑
Prostate – Soft Tissue	❑	❑	❑

MRA

	w/o	w/	w/& w/out
Brain	❑	❑	❑
Neck	❑	❑	❑
Abdomen	❑	❑	❑
Lower Extremity	❑	❑	❑
Upper Extremity	❑	❑	❑

Other: ______

CT SCAN

HEAD AND BRAIN	w/o	w/	w/& w/out
Brain	❑	❑	❑
Ear, Orbit Sella Turcica	❑	❑	❑
Face	❑	❑	❑
Maxila	❑	❑	❑
Neck	❑	❑	❑
CHEST AND ABDOMEN			
Aorta	❑	❑	❑
Abdomen	❑	❑	❑
Chest	❑	❑	❑
Kidneys	❑	❑	❑
Liver	❑	❑	❑
Pancreas	❑	❑	❑
Spleen	❑	❑	❑
Thorax	❑	❑	❑
PELVIS AND PROSTATE			
Pelvis	❑	❑	❑
SPINAL			
Cervical Spine	❑	❑	❑
Thoracic Spine	❑	❑	❑
Lumbar Spine	❑	❑	❑
EXTREMITY			
❑ L/R Lower Extrem.	❑	❑	❑
❑ L/R Upper Extrem.	❑	❑	❑
❑ Calcium Scoring	❑	❑	❑

Other: ______

ULTRASOUND

- ❑ Aorta
- ❑ Gall Bladder
- ❑ Liver
- ❑ Pancreas
- ❑ Pelvis/Prostate
- ❑ Renal
- ❑ Retroperitoneum
- ❑ Spleen
- ❑ Testicles
- ❑ Thyroid
- ❑ Urinary Bladder
- ❑ Echocardiograms
- ❑ Echo Doppler
- ❑ Echo Color Doppler
- ❑ Arterial Doppler/Duplex
- ❑ Venous Doppler/Duplex
- ❑ Renal Artery Duplex
- ❑ Carotid Duplex
- ❑ Aortic Duplex

Other: ______

X-RAY

- ❑ Abdomen-KUB
- ❑ Ankle R ___ L ___
- ❑ Calcaneus R ___ L ___
- ❑ Cervical Spine Views: ______
- ❑ Chest Views: ______
- ❑ Clavicle R ___ L ___
- ❑ Coccyx & Sacrum
- ❑ Elbow R ___ L ___
- ❑ Facial Bones
- ❑ Femur R ___ L ___
- ❑ Fingers R ___ L ___
- ❑ Foot R ___ L ___
- ❑ Forearm R ___ L ___
- ❑ Hand R ___ L ___
- ❑ Hip
- ❑ Knee R ___ L ___

Other: ______

- ❑ Lumbar Spine Views: ______
- ❑ Mandible Views: ______
- ❑ Mastoid
- ❑ Nasal Bones
- ❑ Orbit
- ❑ Paranasal Sinus
- ❑ Pelvis Views: ______
- ❑ Rib Cage
- ❑ Sacro-Lliac
- ❑ Scapula Views: ______
- ❑ Shoulder R ___ L ___
- ❑ Skull
- ❑ Thoracic Spine Views: ______
- ❑ Tib/Fib R ___ L ___
- ❑ Toes R ___ L ___
- ❑ Wrist R ___ L ___

APPOINTMENT

Date: ______ Time: ______

** Please bring your insurance cards, photo ID, referral/authorization and any previous exams of the body area scanned with this prescription.*

Complaints/Diagnosis: ______

Referring Physician: ______

NPI/Tax ID: ______

Phone: ______

Fax: ______

Physician Signature: ______

AUTO/BODILY INJURY

Ins.: ______

DOA: ______ CLM# ______

Attny: ______

MRI patients of age 60+ and CT patients of age 50+ need recent (within 3 months of DOS) blood work for contrast enhanced exam.