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PHYSICIANS ORDER

Monday - Saturday

Extended Evening Hours

Let us Pre-Cert for you!

Patient Name:_______________________________ DOB:_____/_____/_____ Weight:__________lbs.

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

MRI Exam Date/Time: ________________________ Physician Follow Up: ________________________

Referring Physician: ____ Phone #:________________

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

Referring Physician Signature: ____________________NPI #:______________Date:_____/_____/_____

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

MRI

CONTRAST: ☐ **YES** ☐ **NO**

BRAIN / NECK

☐ BRAIN
☐ ORBITS
☐ IAC'S
☐ PITUITARY
☐ SOFT TISSUE NECK
☐ BRACHIAL PLEXUS

SPINE

☐ CERVICAL SPINE
☐ THORACIC SPINE
☐ LUMBAR SPINE
☐ SACRUM
☐ COCCYX

MRA

☐ HEAD (COW)
☐ NECK / CAROTID w / wo
☐ MRV w / wo

ABDOMEN / PELVIS

☐ MRCP
☐ LIVER
☐ RENAL
☐ ADRENALS
☐ PANCREAS
☐ PELVIS- BONY
☐ PELVIS- SOFT TISSUE
☐ PROSTATE

☐ OTHER ______________

EXTREMITY

☐ SHOULDER ☐ L ☐ R
☐ SCAPULA ☐ L ☐ R
☐ HUMERUS ☐ L ☐ R
☐ ELBOW ☐ L ☐ R
☐ FOREARM ☐ L ☐ R
☐ WRIST ☐ L ☐ R
☐ HAND ☐ L ☐ R
☐ HIP ☐ L ☐ R
☐ FEMUR ☐ L ☐ R
☐ KNEE ☐ L ☐ R
☐ LOWER LEG ☐ L ☐ R
☐ ANKLE ☐ L ☐ R
☐ FOOT ☐ L ☐ R

☐ OTHER ______________

OTHER (Specialty Study)

____

____

____

DIAGNOSIS CODE

______________ ______________

______________ ______________

______________ ______________

SPECIAL INSTRUCTIONS

CD with patient? ☐ **Report** ☐ **Viztek** ☐

____

____

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

Please fax this completed form to: 904-491-7701