

## 214-826-6700

Free Patient Parking; Evening and Weekend Appointments Available.

## MRI SCHEDULING ☐ STAT REQUEST NEXT AVAILABLE (48-72 hours) Please fill out completely to expedite your patient referral to the Diagnostic Imaging Center. Fax your request to 214-827-4343 and we will contact your patient to schedule their MRI. An appointment confirmation will be sent to your office. PATIENT INFORMATION: (PLEASE PRINT) DATE: \_\_\_\_\_\_ NAME: \_\_\_\_\_\_DOB: \_\_\_\_\_\_SS#: \_\_\_\_\_ ADDRESS: SEX: M F PREFERRED CONTACT Ph.# :\_\_\_\_\_ ALTERNATE Ph.# :\_\_\_\_ ORDERING PHYSICIAN INFORMATION: \_\_\_\_\_ FAX: \_\_\_\_ PHONE: CONTACT PERSON: \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_ PHYSICIAN SIGNATURE: REOUIRED INSURANCE INFORMATION: INSURANCE CARD ATTACHED (SKIP TO NEXT SECTION) TYPE OF INSURANCE: MEDICARE MEDICAID HMO PPO POS POS PRIMARY INSURANCE CARRIER : PHONE #: PRECERTIFICATION #: GROUP #: MEMBER ID #: SECONDARY INSURANCE CARRIER : \_\_\_\_\_PRECERTIFICATION#: PHONE #: \_\_\_\_\_ MEMBER ID #: GROUP #: WORKING DIAGNOSIS/ICD9 CODE: PLEASE CHECK THE BOX IF THE PATIENT HAS ANY OF THE FOLLOWING CONDITIONS: PACEMAKER ☐ METAL FRAGMENTS IN EYE ☐ PREGNANCY ☐ RECENT SURGERY USING CLIPS OR STAPLES ☐ IMPLANTED DEVICES STUDY REQUESTED 1.5T HIGH-FIELD 3.0T HIGH-FIELD CONTRAST ? YES ■ MRA, Intracranial ■ Brain, General ☐ Shoulder R ■ Brain, Epilepsy ■ Elbow R L MRA, Extracranial ■ Wrist R L ■ Brain, MS MRA, Arch RADIOLOGIST DISCRETION ■ Hip R L ■ Limited, Pituitary MR Venogram Brain Limited, Pineal Knee R MRA, Torso ■ Spine, Cervical ■ Ankle R L ■ MRA, Lower Extremity ■ Spine, Thoracic Brachial Plexus ■ Foot Spine, Lumbar Lumbar Plexus ■ Spine, Myelopathy Chest ■ Spine, Metastatic Abdomen Pelvis COMMENTS: