Patient Name:______________________________ DOB:____________________

SS#:______________ Pt. Home Phone #:______________ Pt. Work Phone #:______________

Weight:____________ Sex: □ Male □ Female

Referring Physician:______________________________ Physician's Office Phone#:______________

Insurance Company:______________________________ Phone #:____________________

Precert Required?: □ Yes □ No Precert #:______________ Work Comp? □ Yes □ No

Diagnosis:______________ Symptoms/Clinical Indications:______________________________

____

Previous Study?: □ Yes □ No Date:______________ Facility:____________________

Previous Spine Surgery?: Level______ Date__________ History of Cancer?:____________________

Other surgeries?:____

SAFETY CONCERNS

Pacemaker/Aneurysm Clips/Biomedical Implants? □ Yes □ No Specify______________________

Injury to eyes with metal? □ Yes □ No ***If yes, has patient had an MRI since injury?*** **□ Yes □ No Date**______

******If yes to injury with metal and no to MRI since injury, patient must have pre-MRI orbit x-rays**

TYPE OF SCAN(S) ORDERED

- □ Brain
- □ Face/Neck/Orbits
- □ Cervical Spine
- □ Thoracic Spine
- □ Lumbar Spine
  - ○ ***weight bearing/ axial loading***
- □ Pelvis
- □ Sacral Spine/SIJ
- □ Soft Tissue
- □ Bony Structure

- □ Neck (Soft Tissue)
- □ Chest
- □ Abdomen
- □ Upper Extremity L R Bilateral
  - ○ Shoulder ○ Elbow ○ Wrist ○ Hand
- □ Lower Extremity L R Bilateral
  - ○ Hip ○ Knee ○ Ankle
  - ○ Foot ○ Thigh ○ Lower Leg

- □ MRA Brain
- □ MRA Neck
- □ MRA Chest
- □ MRA Abdomen
- □ MRA Pelvis
- □ MRA Lower Extremity
- □ Arthrogram
- □ Other______________

Contrast? (Circle one): Without With & Without **Sedation? (Circle one)**: Yes No

SPECIAL INSTRUCTIONS

Call patient to schedule (Circle one) Yes No

Report Status (Circle one) STAT ASAP Routine

Desired Contact # (circle one and provide number) *Office *Cell *Pager #______________________

Allergies:____

______________________________ Date:____________________

Physician Signature Required

THANK YOU FOR YOUR REFERRAL!

Please fax to: (317) 706-3417
Meridian MRI
8805 N. Meridian St. Indianapolis, IN 46260
Phone (317) 706-SCAN