MRI Referral Form

ADVANCED PATIENT IMAGING LLC

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APPOINTMENT

DATE: _____

TIME: _____

If you must reschedule or cancel your appointment, please give at least 24 hours notice.

_____
Referring Physician

_____
Clinic/Office

_____
Phone Fax

Patient's Name

_____
Last First MI

_____
DOB (MM/DD/YYYY) Age Weight Home Phone

Requested MRI Order – Please check all that apply:

**For any MRI with contrast, lab work to verify creatinine levels is needed on the following patient types: over age 70, diabetic, decreased kidney function, only one kidney present or known kidney disease.*

❑ Without Contrast • ❑ With/Without Contrast*

MRI of:

❑ Brain	❑ MRA Carotids
❑ Cervical Spine	❑ MRA Brain
❑ Thoracic Spine	❑ Pelvis
❑ Lumbar Spine	❑ Knee - ❑ Right / ❑ Left
❑ Brachial Plexus	❑ Shoulder - ❑ Right / ❑ Left
❑ Neck for Soft Tissue	❑ Other (specify) _____

Clinical Indications: _____

_____

Report Delivery - ❑ Fax:_____ / ❑ Email:_____

⌧ Physician Signature: _____ Date: _____