NORTHWEST IMAGING

1460 E. Bert Kours Industrial Loop
Shreveport, LA 71105
www.capitolimagingcenters.com
Tax ID: 202434713

PATIENT SCHEDULING REFERRAL FORM

GE EXCITE HIGH FIELD OPEN MAGNET

Patient Name

Appointment Date / Time

Primary Phone

Date of Birth / Weight / Height

Diagnosis

ICD10

Office Phone

Referring Physician

Office Fax

Physician Signature

Insurance / Attorney :

Authorization #:

PLEASE FAX BOTH SIDES OF PATIENT'S INSURANCE CARD WITH THIS REQUEST

318-425-5001

MRI ❑ Without contrast ❑ With contrast ❑ With and without contrast

- ❑ Brain
  - ❑ Pituitary
  - ❑ IAC
  - ❑ Orbits
- ❑ Sinus
- ❑ Cervical Spine
- ❑ Thoracic Spine
- ❑ Lumbar Spine
- ❑ Soft Tissue Neck
- ❑ Other

- ❑ Shoulder
- ❑ Humerus
- ❑ Elbow
- ❑ Forearm
- ❑ Wrist
- ❑ Hand
- ❑ Finger
- ❑ Hip
- ❑ Knee
- ❑ Upper Leg (Femur)
- ❑ Lower Leg (Tibia)
- ❑ Ankle
- ❑ Foot
- ❑ Toes

❑ RT ❑ LT ❑ BILAT

- ❑ Abdomen
  - ❑ Adrenals
  - ❑ Pancreas/MRCP
  - ❑ Kidneys
- ❑ Chest
- ❑ Brachial Plexus
- ❑ Sacrum/Coccyx
- ❑ S I Joints
- ❑ Pelvis
  - ❑ Soft Tissue
  - ❑ Bony

MRA ❑ Without contrast ❑ With contrast ❑ With and without contrast

- ❑ Brain
- ❑ Neck
- ❑ Other (Describe) _____

A signed report will be faxed to the number provided above. A CD of images can be provided upon request or call to set-up viewing images on our PACS system in your office.

MAGNETIC RESONANCE IMAGING
ACR
AMERICAN COLLEGE OF RADIOLOGY
ACCREDITED FACILITY

THANK YOU FOR YOUR REFERRAL

To RE-ORDER additional Referral Pads, contact Capitol Imaging Services at

318-425-1001

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