



REFERRAL / SCHEDULE BY FAX FORM

M.R. Imaging Systems: (F) 318-443-7696 • (P) 318-443-7674
Open Air MRI of CENLA: (F) 318-445-8845 • (P) 318-445-6736

Patient Name _____ Tel: _____ Date: _____

Patient Insurance _____ Policy # _____ Group # _____ D.O.B. _____

Workers Comp _____ Atty _____ Authorization # _____

Diagnosis – Written and/or ICD-10 Code (Required) _____

Physician's Signature (Required) _____ Physician Name (please print) _____

Call Preliminary Reading Tel # _____ After Hours Tel # _____

Address _____ Tel: _____ Fax: _____

Modalities and scans in **RED** are performed exclusively at Open Air MRI of CENLA

CT	w/o	w	w & w/o	MRI	w/o	w & w/o	MR Angiography	w/o	w & w/o
<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head			<input type="checkbox"/> Brain	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Brain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Brain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Carotid Artery	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> NeuroQuant Volumetric MRI			<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High Resolution Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> IAC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Aorta	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Extremity <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Orbit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Thoracic Aorta	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lower Extremity <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Pituitary Gland	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Renal	<input type="checkbox"/>	<input type="checkbox"/>
Body Part _____				<input type="checkbox"/> Sinus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other _____		
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> TMJ	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Orbits/Temporal Bone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Body			MR Arthrogram		
<input type="checkbox"/> Pelvis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	RT <input type="checkbox"/>	LT <input type="checkbox"/>
<input type="checkbox"/> Renal Stone Protocol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> MRCP			<input type="checkbox"/> Hip	RT <input type="checkbox"/>	LT <input type="checkbox"/>
<input type="checkbox"/> Sinus <input type="checkbox"/> Limited <input type="checkbox"/> Full	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Adrenal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Wrist	RT <input type="checkbox"/>	LT <input type="checkbox"/>
<input type="checkbox"/> C Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Elbow	RT <input type="checkbox"/>	LT <input type="checkbox"/>
<input type="checkbox"/> L Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Knee	RT <input type="checkbox"/>	LT <input type="checkbox"/>
<input type="checkbox"/> Sacrum/Coccyx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Liver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Ankle	RT <input type="checkbox"/>	LT <input type="checkbox"/>
<input type="checkbox"/> T Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Pelvis	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Uterus	<input type="checkbox"/>	<input type="checkbox"/>			
				<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/>	<input type="checkbox"/>			
Nuclear Medicine				Spine			<input type="checkbox"/> Check here if your patient is to take a CD with them		
<input type="checkbox"/> PET/CT Skull Base--Mid Thigh (F18 FDG)				<input type="checkbox"/> Brachial Plexus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> STAT – Call Report		
<input type="checkbox"/> PET/CT Skull Base--Mid Thigh (F18 FDG)				<input type="checkbox"/> Cervical Spine	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> PET/CT Axumin (F18 Fluciclovine)				<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> PET/CT Brain Imaging (F18 FDG)				<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> PET/CT Brain Imaging (Amyvid)				<input type="checkbox"/> Sacrum/SI Joints	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> PET/CT Bone Scan (Sodium Fluoride)				<input type="checkbox"/> Other _____					
				Joint					
X-Ray				<input type="checkbox"/> Shoulder <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Chest PA & LAT				<input type="checkbox"/> Upper Arm <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Cervical				<input type="checkbox"/> Elbow <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Thoracic				<input type="checkbox"/> Forearm <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Lumbar				<input type="checkbox"/> Wrist <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Sinus				<input type="checkbox"/> Hand <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> KUB/Flat/Erect				<input type="checkbox"/> Finger <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Ribs				<input type="checkbox"/> Hip <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Pelvis				<input type="checkbox"/> Thigh/Femur <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Extremity <input type="checkbox"/> LT <input type="checkbox"/> RT				<input type="checkbox"/> Knee <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>			
Body Part _____				<input type="checkbox"/> Lower Leg <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>			
				<input type="checkbox"/> Ankle <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>			
				<input type="checkbox"/> Foot <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>			
				<input type="checkbox"/> Other Extremity _____					

Appointment Location: M.R. Imaging Systems Open Air MRI of CENLA

Patient Work Telephone: _____ Patient Cell: _____

Appointment Date _____ Time _____ Today's Date _____ Initials _____