

REFERRAL / SCHEDULE BY FAX FORM

Scheduling: (F) 337-984-7604 • (P) 337-984-2036

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: _____

MRI

Head

- | | w/o | w & w/o |
|---|--------------------------|--------------------------|
| <input type="checkbox"/> Brain | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> IAC | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Orbit, face & neck | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Pituitary | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Soft Tissue Neck | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> TMJ | <input type="checkbox"/> | <input type="checkbox"/> |

Spine

- | | w/o | w & w/o |
|---|--------------------------|--------------------------|
| <input type="checkbox"/> Cervical Spine | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Thoracic Spine | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Lumbar Spine | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Sacrum | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Coccyx | <input type="checkbox"/> | <input type="checkbox"/> |

Chest

- | | | |
|---|--------------------------|--------------------------|
| <input type="checkbox"/> Breast - bilateral | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Chest | <input type="checkbox"/> | <input type="checkbox"/> |

Musculoskeletal

- | | w/o | w & w/o | w |
|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Humerus <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Elbow <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Forearm <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Wrist <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hand <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hip <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Femur <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Tibula/Fibula <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Knee <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Ankle <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Foot <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Pelvis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

MRA

- | | w/o | w & w/o | w |
|-----------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Neck | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Chest | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <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"/> |
| <input type="checkbox"/> Carotids | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> MRV Head | <input type="checkbox"/> | | |
| <input type="checkbox"/> Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Special Instructions

Check here if your patient is to take a CD with them

Appointment Location: 935 Camellia Blvd #101 • Lafayette LA 70508 (in the village of River Ranch)

Patient Work Telephone: _____ Patient Cell: _____

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