HOMOSASSA OPEN MRI

REFERRAL / SCHEDULE BY FAX FORM

Scheduling: (F) 352-628-4801 • (P) 352-628-4800

Patient Name_____ Tel: _____ Date:_____

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

Workers Comp / PIP / Auto _____ 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

	w/o	w & w/o
Head		
☐ Brain	☐	☐
☐ IAC	☐	☐
☐ Orbit	☐	☐
☐ Pituitary	☐	☐
☐ Soft Tissue Neck	☐	☐
☐ TMJ	☐	☐
Musculoskeletal		
☐ Shoulder	☐	☐
☐ Humerus	☐	☐
☐ Elbow	☐	☐
☐ Wrist	☐	☐
☐ Hand	☐	☐
☐ Hip	☐	☐
☐ Knee	☐	☐
☐ Ankle	☐	☐
☐ Foot	☐	☐
Spine		
☐ Cervical Spine	☐	☐
☐ Thoracic Spine	☐	☐
☐ Lumbar Spine	☐	☐
Chest		
☐ Chest	☐	☐
☐ Pelvis	☐	☐
☐ Abdomen - Liver	☐	☐
☐ Abdomen - Kidneys	☐	☐
☐ Other_____	☐	☐

MRA

	w/o	w
☐ Carotid/Verterbrals	☐	☐
☐ Head (Circle of Willis)	☐	☐

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

X-Ray (Please specify)

- ☐ Chest PA
- ☐ Chest PA/LAT
- ☐ Soft Tissue Neck
- ☐ KUB
- ☐ Skull
- ☐ Sinus
- ☐ Cervical Spine
  - ☐ AP & LAT
  - ☐ 5 Views
  - ☐ Flexion & Extension
- ☐ Thoracic Spine
- ☐ Lumbar Spine
  - ☐ AP & LAT
  - ☐ 5 Views
  - ☐ Flexion & Extension
- ☐ Sacrum & Coccyx
- ☐ Scoliosis
- ☐ S.I. Joints
- ☐ Pelvis

☐ Ribs	☐ Right	☐ Left
☐ Clavicle	☐ Right	☐ Left
☐ Shoulder	☐ Right	☐ Left
☐ Humerus	☐ Right	☐ Left
☐ Elbow	☐ Right	☐ Left
☐ Forearm	☐ Right	☐ Left
☐ Wrist	☐ Right	☐ Left
☐ Hand	☐ Right	☐ Left
☐ Hip	☐ Right	☐ Left
☐ Femur	☐ Right	☐ Left
☐ Knee	☐ Right	☐ Left
☐ Tib-Fib	☐ Right	☐ Left
☐ Anke	☐ Right	☐ Left
☐ Foot	☐ Right	☐ Left
☐ Calcaneous	☐ Right	☐ Left

☐ Other _____

_____

_____

Appointment Location: **8464 West Aquaduct Street • Homosassa FL 34448**

Patient Work Telephone: _____ Patient Cell: _____

Appointment Date_____ Time_____ Today's Date_____ Initials_____