

REFERRAL / SCHEDULE BY FAX FORM

Scheduling: (F) 601-483-4516 • (P) 601-483-4339

Appointment Date _____ Time _____ Initials _____

Patient Name _____ DOB: _____ Today's Date _____

Home # _____ Work # _____ Cell # _____

Patient Insurance _____ Policy # _____ Group # _____

Workers Comp _____ Atty _____ Authorization # _____

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

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

Address _____ Tel: _____ Fax _____

Comments _____

<u>MRI</u>	w/o	w	w & w/o	<u>MRA</u>	w/o	w & w/o
Head				<input type="checkbox"/> Brain	<input type="checkbox"/>	
<input type="checkbox"/> Brain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Carotids	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> IAC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Subclavian	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Orbit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Aorta	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pituitary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Renals	<input type="checkbox"/>	<input type="checkbox"/>
Spine				<u>MRV</u>		
<input type="checkbox"/> Cervical Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Brain	<input type="checkbox"/>	w/o
<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Brachial Plexus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Body						
<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> MRCP	<input type="checkbox"/>					
<input type="checkbox"/> Liver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Adrenal Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Pancreas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Pelvis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Musculoskeletal			w/o	w	w & w/o	
<input type="checkbox"/> Hip	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Shoulder	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Arm	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
<input type="checkbox"/> Lower Leg	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Leg/Thigh	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>

IMAGE AND REPORT PREFERENCE

Report Only

Send disk with patient and fax report

Patient's previous images are necessary for comparison to obtain the most accurate results.

If your patient has had surgery on the area or a history of cancer, please notify us.

ABOUT YOUR MRI EXAM

Magnetic Resonance Imaging (MRI) uses a strong magnetic field and radio waves to produce pictures of internal body structures. MRI is a painless procedure that uses no X-rays or radiation. An MRI scanner produces cross-sectional images which allow physicians to see internal structures in great detail. Because of the magnetic field, patients with cardiac pacemaker, cerebral aneurysm clips, or ear implants may not be scanned.

BEFORE THE EXAM. If you are taking any medications, especially pain medication, take them as you normally would. You should wear comfortable clothing with no metal, or a gown will be provided for you to change into.

THE EXAM. A magnetic resonance examination is a simple and safe procedure. You will be asked to remove watches, jewelry, credit and ATM cards, coins and any other metallic objects from your possession. A technologist will explain the test to you, then ask you to lie down on a padded table. The table will slide forward, positioning the part of your body being scanned into the center of the magnet. The machine will make loud knocking noises during the imaging sequences. Ear plugs or headphones with music will be provided for your comfort.

Typical exam times range between 20 and 30 minutes, although some exams may take longer. The most important part of the exam for you is to lie very still. This is crucial because the scanner is very sensitive, and any movement during the sequences will blur the pictures, degrading the diagnostic quality of the examination.

Occasionally, a contrast agent is used. This is a substance that enhances the sensitivity of the images. This contrast may help the radiologist interpret the images from your exam under certain circumstances. If needed, this will be injected into a vein in your arm.

AFTER THE EXAM. Following the exam, you may leave. There are no after affects from MRI. The images are then processed for interpretation by the radiologist. Your provider will receive your results within approximately 24 hours. Please call your referring provider for test results.

The following items may exclude you from having an MRI exam. Please contact Imaging Center of Meridian at 601-483-4339 if any of these apply to you, or if you have any questions.

- Pacemaker
- History of metal fragment in eyes
- Pregnancy
- Unable to lie flat
- Weight of over 350 lbs
- Claustrophobia
- Cerebral Aneurysm Clip

-
- Please bring any previous x-rays or test results with you on the day of your exam.
 - Bring your I.D. cards and insurance cards.
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**An appointment time has been specially reserved for you.
Please arrive 15 minutes prior to your scheduled appointment.**

LOCATION MAP

- A** Imaging Center of Meridian
- B** Anderson Regional Medical Center
- C** Rush Foundation Hospital
- D** Anderson Regional Medical Center South
- E** Walgreens Pharmacy

