SOUTHERN IMAGING SPECIALISTS

REFERRAL / SCHEDULE BY FAX FORM

Scheduling: (P) 334-279-8370 • (F) 334-279-8572

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

	w/	w/o	w & w/o
☐ Brain	☐	☐	☐
☐ Orbits	☐	☐	☐
☐ IAC's	☐	☐	☐
☐ Pituitary	☐	☐	☐
☐ Cervical Spine	☐	☐	☐
☐ Soft Tissue Neck	☐	☐	☐
☐ Brachial Plexus	☐	☐	☐
☐ Thoracic Spine	☐	☐	☐
☐ Lumbar Spine	☐	☐	☐
☐ Abdomen	☐	☐	☐

MRA

☐ Brain

☐ Carotids

☐ Abdominal Aorta

☐ Renals

MRV

☐ Brain

MRI

		w/	w/o	w & w/o
☐ Shoulder	☐ R ☐ L	☐	☐	☐
☐ Elbow	☐ R ☐ L	☐	☐	☐
☐ Wrist	☐ R ☐ L	☐	☐	☐
☐ Hand	☐ R ☐ L	☐	☐	☐
☐ Finger/Thumb	☐ R ☐ L	☐	☐	☐
☐ Hip	☐ R ☐ L	☐	☐	☐
☐ Knee	☐ R ☐ L	☐	☐	☐
☐ Ankle-Hind Foot	☐ R ☐ L	☐	☐	☐
☐ Fore-Midfoot	☐ R ☐ L	☐	☐	☐
☐ Toes	☐ R ☐ L	☐	☐	☐
☐ Other		☐	☐	☐

_____

_____

_____

Arthrogram

☐ Shoulder ☐ R ☐ L

☐ Other ☐ R ☐ L

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.

Image/Report Preference

☐ **Report Only** ☐ **Deliver Disc and Report** ☐ **Send Disc with Patient and Fax Report**

Appointment Location: **465 Saint Lukes Drive • Montgomery AL 36117**

Patient Work Telephone: _____ Patient Cell: _____

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