

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: _____

<u>MRI</u>	w/	w/o	w & w/o	<u>MRI</u>	w/	w/o	w & w/o
<input type="checkbox"/> Brain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Orbits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Elbow	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> IAC's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Wrist	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pituitary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cervical Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Finger/Thumb	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Brachial Plexus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Knee	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Ankle-Hind Foot	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Fore-Midfoot	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Toes	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> Other		<input type="checkbox"/>	<input type="checkbox"/>

MRA

Brain _____

Carotids _____

Abdominal Aorta _____

Renals _____

MRV

Brain _____

Arthrogram

Shoulder R L

Other R L

Patient's previous test films 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 _____