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 | ☐ R ☐ L | ☐ | ☐ |
| ☐ Humerus | ☐ R ☐ L | ☐ | ☐ |
| ☐ Elbow | ☐ R ☐ L | ☐ | ☐ |
| ☐ Wrist | ☐ R ☐ L | ☐ | ☐ |
| ☐ Hand | ☐ R ☐ L | ☐ | ☐ |
| ☐ Hip | ☐ R ☐ L | ☐ | ☐ |
| ☐ Knee | ☐ R ☐ L | ☐ | ☐ |
| ☐ Ankle | ☐ R ☐ L | ☐ | ☐ |
| ☐ Foot | ☐ R ☐ L | ☐ | ☐ |
| **Spine** | | | |
| ☐ Cervical Spine | | ☐ | ☐ |
| ☐ Thoracic Spine | | ☐ | ☐ |
| ☐ Lumbar Spine | | ☐ | ☐ |
| **Pelvic/Abdomen** | | | |
| ☐ Pelvis | | ☐ | ☐ |
| ☐ Abdomen - Liver | | ☐ | ☐ |
| ☐ Abdomen - Kidneys | | ☐ | ☐ |
| ☐ Other____________ | | ☐ | ☐ |

## MRA

☐ 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 | ☐ R | ☐ L |
| ☐ Clavicle | ☐ R | ☐ L |
| ☐ Shoulder | ☐ R | ☐ L |
| ☐ Humerus | ☐ R | ☐ L |
| ☐ Elbow | ☐ R | ☐ L |
| ☐ Forearm | ☐ R | ☐ L |
| ☐ Wrist | ☐ R | ☐ L |
| ☐ Hand | ☐ R | ☐ L |
| ☐ Hip | ☐ R | ☐ L |
| ☐ Femur | ☐ R | ☐ L |
| ☐ Knee | ☐ R | ☐ L |
| ☐ Tib-Fib | ☐ R | ☐ L |
| ☐ Anke | ☐ R | ☐ L |
| ☐ Foot | ☐ R | ☐ L |
| ☐ Calcaneous | ☐ R | ☐ L |

☐ Other ______________________

______________________

______________________

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

Patient Work Telephone: ______________________ Patient Cell: ______________________

Appointment Date ______________________ Time ____________ Today's Date ____________ Initials ________