



M.R. IMAGING
SYSTEMS



Open Air MRI
of CENLA

REFERRAL / SCHEDULE BY FAX FORM

M.R. Imaging Systems: (P) 318-443-7674 • (F) 318-443-7696
Open Air MRI of CENLA: (P) 318-445-6736 • (F) 318-445-8845

Patient Information

Patient Name _____ Tel: _____ D.O.B.: _____
Patient Work Tel: _____ Patient Cell: _____
Patient Insurance _____ Policy # _____ Group # _____
Workers Comp _____ Atty _____ Authorization # _____

Physician Information

Diagnosis – Written and/or ICD-10 Code (Required) _____
Physician's Signature (Required) _____ Physician Name (please print) _____
Address _____ Tel: _____ Fax: _____
Call Preliminary Reading Tel # _____ After Hours Tel # _____

Modalities and scans in **RED** are performed exclusively at Open Air MRI of CENLA

CT

	w/o	w	w & w/o
<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Brain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> High Resolution Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Extremity <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lower Extremity <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Body Part _____			
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Orbits/Temporal Bone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pelvis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Renal Stone Protocol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sinus <input type="checkbox"/> Limited <input type="checkbox"/> Full	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> C Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> L Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sacrum/Coccyx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> T Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PET/CT

☐ PET/CT Skull Base—Mid Thigh (F18 FDG)
☐ PET/CT Whole Body—Head-Toe (F18 FDG)
☐ PET/CT Axumin (F18 Fluciclovine)
☐ PET/CT Brain Imaging (F18 FDG)
☐ PET/CT Brain Imaging (Amyvid)
☐ PET/CT Bone Scan (Sodium Fluoride)
☐ PET/CT Pylarify (PSMA/F18 Piflufolstat)

X-Ray

☐ Chest PA & LAT
☐ Cervical
☐ Thoracic
☐ Lumbar
☐ Sinus
☐ KUB/Flat/Erect
☐ Ribs
☐ Pelvis
☐ Extremity ☐ LT ☐ RT
Body Part _____

MRI

	w/o	w & w/o
Head		
<input type="checkbox"/> Brain	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Volumetric		
<input type="checkbox"/> IAC	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Orbit	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pituitary Gland	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sinus	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> TMJ	<input type="checkbox"/>	<input type="checkbox"/>
Body		
<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> MRCP		
<input type="checkbox"/> Adrenal	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chest	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Kidney	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Liver	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pelvis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Uterus	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/>	<input type="checkbox"/>
Spine		
<input type="checkbox"/> Brachial Plexus	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cervical Spine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sacrum/SI Joints	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other _____		
Joint		
<input type="checkbox"/> Shoulder <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Upper Arm <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Elbow <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Forearm <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Wrist <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hand <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Finger <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hip <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Thigh/Femur <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Knee <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lower Leg <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ankle <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot <input type="checkbox"/> LT <input type="checkbox"/> RT	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other Extremity _____		

MR Angiography

	w/o	w & w/o
<input type="checkbox"/> Brain	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Carotid Artery	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abdominal Aorta	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Thoracic Aorta	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Renal	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other _____		

MR Arthrogram

<input type="checkbox"/> Shoulder	RT <input type="checkbox"/>	LT <input type="checkbox"/>
<input type="checkbox"/> Hip	RT <input type="checkbox"/>	LT <input type="checkbox"/>
<input type="checkbox"/> Wrist	RT <input type="checkbox"/>	LT <input type="checkbox"/>
<input type="checkbox"/> Elbow	RT <input type="checkbox"/>	LT <input type="checkbox"/>
<input type="checkbox"/> Knee	RT <input type="checkbox"/>	LT <input type="checkbox"/>
<input type="checkbox"/> Ankle	RT <input type="checkbox"/>	LT <input type="checkbox"/>

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

☐ STAT – Call Report

Appointment Location:

☐ **M. R. Imaging Systems**
211 N. 3rd Street, Suite B
Alexandria, LA 71301
NPI: 1780639559

☐ **Open Air MRI of CENLA**
5413 Jackson Street
Alexandria, LA 71303
NPI: 1528081924

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