

# REFERRAL / SCHEDULE BY FAX FORM

Scheduling: (F) 337-984-7604 • (P) 337-984-2036

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

#### Head

- |   | w/o                      | w & w/o                  |
|---|--------------------------|--------------------------|
| <input type="checkbox"/> Brain              | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> IAC                | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Orbit, face & neck | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Pituitary          | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Soft Tissue Neck   | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> TMJ                | <input type="checkbox"/> | <input type="checkbox"/> |

#### Spine

- |   | w/o                      | w & w/o                  |
|---|--------------------------|--------------------------|
| <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         | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Coccyx         | <input type="checkbox"/> | <input type="checkbox"/> |

#### Chest

- |   |                          |                          |
|---|--------------------------|--------------------------|
| <input type="checkbox"/> Breast - bilateral | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Chest              | <input type="checkbox"/> | <input type="checkbox"/> |

#### Musculoskeletal

- |  | w/o                      | w & w/o                  | w                        |
|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Shoulder <input type="checkbox"/> L <input type="checkbox"/> R      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Humerus <input type="checkbox"/> L <input type="checkbox"/> R       | <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"/> Forearm <input type="checkbox"/> L <input type="checkbox"/> R       | <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"/> Hand <input type="checkbox"/> L <input type="checkbox"/> R          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hip <input type="checkbox"/> L <input type="checkbox"/> R           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Femur <input type="checkbox"/> L <input type="checkbox"/> R         | <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"/> Knee <input type="checkbox"/> L <input type="checkbox"/> R          | <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"/> Foot <input type="checkbox"/> L <input type="checkbox"/> R          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Pelvis  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

### MRA

- |                                   | w/o                      | w & w/o                  | w                        |
|-----------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Head     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Neck     | <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"/> Pelvis   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Carotids | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> MRV Head | <input type="checkbox"/> |                          |                          |
| <input type="checkbox"/> Other    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

### SPECIAL INSTRUCTIONS

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DATE OF ACCIDENT:**

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

Appointment Location: 935 Camellia Blvd #101 • Lafayette LA 70508 (in the village of River Ranch)

Patient Work Telephone: \_\_\_\_\_ Patient Cell: \_\_\_\_\_

Appointment Date \_\_\_\_\_ Time \_\_\_\_\_ Today's Date \_\_\_\_\_ Initials \_\_\_\_\_

# 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.** Fasting is not required before your MRI exam. You may eat and drink as usual. 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 15 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. The results are not immediately available. The radiologist will contact your physician to convey the information ascertained from the scan. Please call only your referring doctor for test results.

The following items may exclude you from having an MRI exam. Please contact Advanced Imaging of Lafayette at 337-984-2036 if any of these apply to you, or if you have any questions.

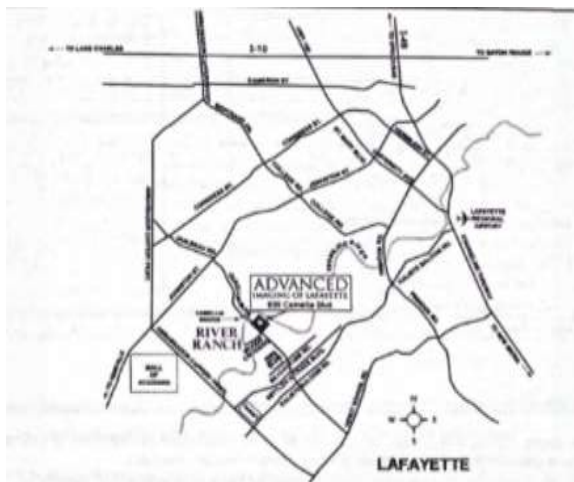
- Pacemaker
- Unable to lie flat
- Cerebral Aneurysm Clip
- History of metal fragment in eyes
- Weight of over 300 lbs
- Pregnancy
- Claustrophobia

- 
- Please bring any previous x-rays or test results with you on the day of your exam.
  - Bring your I.D. cards or insurance forms.
- 

**An appointment time has been specially reserved for you.  
Please arrive 30 minutes prior to your scheduled appointment.**

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	Yes	No
Previous CT/MRI:	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker:	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Aneurysm Clip:	<input type="checkbox"/>	<input type="checkbox"/>
Metallic Prosthesis Clips:	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Bodies:	<input type="checkbox"/>	<input type="checkbox"/>
Type & Locations: _____		
Special Instructions: _____		
_____		
_____		
_____		



River Ranch | 935 Camellia Blvd #101 | Lafayette LA 70508

