ADVANCED IMAGING of Lafayette

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

	w/o	w & w/o
Head		
☐ Brain	☐	☐
☐ IAC	☐	☐
☐ Orbit, face & neck	☐	☐
☐ Pituitary	☐	☐
☐ Soft Tissue Neck	☐	☐
☐ TMJ	☐	☐
Spine		
☐ Cervical Spine	☐	☐
☐ Thoracic Spine	☐	☐
☐ Lumbar Spine	☐	☐
☐ Sacrum	☐	☐
☐ Coccyx	☐	☐
Chest		
☐ Breast - bilateral	☐	☐
☐ Chest	☐	☐

Musculoskeletal		w/o	w & w/o	w
☐ Shoulder	☐ L ☐ R	☐	☐	☐
☐ Humerus	☐ L ☐ R	☐	☐	☐
☐ Elbow	☐ L ☐ R	☐	☐	☐
☐ Forearm	☐ L ☐ R	☐	☐	☐
☐ Wrist	☐ L ☐ R	☐	☐	☐
☐ Hand	☐ L ☐ R	☐	☐	☐
☐ Hip	☐ L ☐ R	☐	☐	☐
☐ Femur	☐ L ☐ R	☐	☐	☐
☐ Tibula/Fibula	☐ L ☐ R	☐	☐	☐
☐ Knee	☐ L ☐ R	☐	☐	☐
☐ Ankle	☐ L ☐ R	☐	☐	☐
☐ Foot	☐ L ☐ R	☐	☐	☐
☐ Pelvis		☐	☐	☐

MRA

	w/o	w & w/o	w
☐ Head	☐	☐	☐
☐ Neck	☐	☐	☐
☐ Chest	☐	☐	☐
☐ Pelvis	☐	☐	☐
☐ Carotids	☐	☐	☐
☐ MRV Head	☐		
☐ Other	☐	☐	☐

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 _____