



1460 E. Bert Kours Industrial Loop #708
Shreveport, LA 71105
www.capitolimagingsservices.com

PATIENT SCHEDULING REFERRAL FORM

Tax ID: 202434713

<input type="text"/>	<input type="text"/>
Patient Name	Appointment Date / Time
<input type="text"/>	<input type="text"/>
Primary Phone	Date of Birth / Weight / Height
<input type="text"/>	<input type="text"/>
Diagnosis	ICD10
<input type="text"/>	<input type="text"/>
Office Phone	Referring Physician
<input type="text"/>	<input type="text"/>
Office Fax	Physician Signature
<input type="text"/>	<input type="text"/>
Insurance / Attorney :	Authorization #:
<input type="text"/>	<input type="text"/>

**PLEASE FAX BOTH SIDES OF PATIENT'S INSURANCE CARD WITH THIS REQUEST
318-425-5001**

MRI	Without contrast	With contrast	With and without contrast			
Brain		Shoulder	RT	LT	BILAT	Abdomen
Pituitary		Humerus	RT	LT	BILAT	Adrenals
IAC		Elbow	RT	LT	BILAT	Pancreas/MRCP
Orbits		Forearm	RT	LT	BILAT	Kidneys
Sinus		Wrist	RT	LT	BILAT	Chest
Cervical Spine		Hand	RT	LT	BILAT	Brachial Plexus
Thoracic Spine		Finger	RT	LT	BILAT	Sacrum/Coccyx
Lumbar Spine		Hip	RT	LT	BILAT	S I Joints
Soft Tissue Neck		Knee	RT	LT	BILAT	Pelvis
Other <input type="text"/>		Upper Leg (Femur)	RT	LT	BILAT	Soft Tissue
<input type="text"/>		Lower Leg (Tibia)	RT	LT	BILAT	Bony
		Ankle	RT	LT	BILAT	
		Foot	RT	LT	BILAT	
		Toes	RT	LT	BILAT	

MRA	Without contrast	With contrast	With and without contrast
Brain			
Neck			
Other (Describe)	<input type="text"/>		
<input type="text"/>			

A signed report will be faxed to the number provided above. A CD of images can be provided upon request or call to set-up viewing images on our PACS system in your office.



THANK YOU FOR YOUR REFERRAL