ANGELO MRI

Your health. **Your choice.** Your MRI.

FOR OFFICE USE ONLY

DATE RECEIVED: _____

CALL PATIENT TO SCHEDULE: _____

SCHEDULED: _____

DATE OF PATIENT'S FOLLOW-UP WITH REFERRING PHYSICIAN: _____

PHYSICIAN FAX NUMBER: _____

MRI/MRA PRESCRIPTION

Order expires in 30 days.

DATE: _____ *MM/DD/YYYY*

PATIENT'S NAME: _____ *Last, First, Middle* **DATE OF BIRTH:** _____ *MM/DD/YYYY*

APPOINTMENT DATE: _____ *MM/DD/YYYY* **APPOINTMENT TIME:** _____ ☐ **AM** ☐ **PM** **GENDER:** ☐ **MALE** ☐ **FEMALE**

TYPE OF STUDY REQUESTED:

☐ **With Contrast** ☐ **Without Contrast** ☐ **With/Without Contrast**

☐ **I have prescribed sedation medication.** ☐ **Creatinine labs have been conducted as needed.**

SEE MRI/MRA CHART FOR CODING

MRI:

_____ Brain
_____ Orbit, Face, and Neck (Pituitary)
_____ TMJ
_____ Cervical Spine
_____ Thoracic Spine
_____ Lumbar Spine
_____ Sacrum/Coccyx
_____ Chest
_____ Shoulder L / R
_____ Elbow L / R
_____ Wrist L / R
_____ Humerus
_____ Forearm
_____ Abdomen
_____ Pelvis
_____ Hip L / R
_____ Thigh
_____ Knee L / R
_____ Lower Leg
_____ Ankle L / R
_____ Foot L / R
_____ Other
_____

Bilateral Procedure Technologist

_____

_____ Left
_____ Right

MRA:

_____ Brain
_____ Angio Head/Neck
_____ Chest
_____ Pelvis
_____ Upper Extremity
_____ Lower Extremity
_____ Abdomen

Diagnosis _____ **ICD9 Code** _____

☐ **PATIENT HAS DONE WELDING OR GRINDING, SO ORBIT X-RAYS WILL BE FAXED TO ANGELO MRI WITH A SIGNED CLEARANCE.**

Special instructions _____

☐ Give CD to patient ☐ STAT – Call with verbal report ☐ STAT – Fax report

Referring Physician Printed Name _____

Physician Telephone Number _____ **Fax** _____

Physician Signature _____

4114 South Jackson Street ▪ San Angelo, Texas 76903 ▪ O: 325.703.6741 ▪ F: 325.703.6742
info@angelomri.com ▪ www.angelomri.com