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Atlanta, GA 30339
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support@mrihealthgroup.com

# PATIENT MRI ORDER FORM

## Patient Information

Patient Name: ______________________________ Date: ____________
Patient Phone #: ______________________________ DOB: ____________
Email: ____________________ Preferred Method of Contact: ▯ Email ▯ Call ▯ Text

Billing Information: ▯ Health ▯MVA ▯ W/C ▯ Medpay ▯ Other: ________ Policy#: ____________
Insurance Company: ____________________ Claim #: ____________________
Attorney Name: ____________________ Date of Injury: ____________________
Attorney Phone #: ____________________ Fax #: ____________________
Attorney Email: ____________________ ▯ Worker's Comp ▯ MVA ▯ Slip & Fall

## Requested MRI / MRA Procedure

ICD10 Codes: ____________ ____________ ____________ ____________
Diagnosis/Symptoms: ________________________________________

▯ W/O Contrast
▯ Bilateral
▯ Brain
▯ Brachial Plexus
▯ Cervical
▯ Thoracic (Spine)
▯ Lumbar
▯ Chest
▯ Pelvis
▯ Abdomen

▯ Ankle L / R
▯ Calf (Tib/Fib) L / R
▯ Elbow L / R
▯ Foot L / R
▯ Forearm L / R
(Radius and Ulna)
▯ Hip L / R
▯ Humerus L / R
▯ Knee L / R
▯ Shoulder L / R

▯ Thigh L / R
▯ Wrist L / R
▯ Brain MRA
▯ Neck MRA (Carotid Bifurcation)
▯ Abdomen MRA
▯ Pelvis MRA (Iliac Bifurcation)

▯ CD
▯ STAT
▯ FAX REPORT
▯ CALL REPORT TO: ____________

▯ Other Scan Type: ____________________

## Physician Information

I have requested the above exam(s) based on the patient's history and diagnosis.
The exam(s) are necessary to diagnose accurately and develop a sound treatment plan.

Physician Signature: ______________________________ Date: ____________
Physician Name: ______________________________ Phone #: ____________
Physician NPI#: ______________________________ Fax: ____________

***PLEASE EMAIL THIS FORM TO SUPPORT@MRIHEALTHGROUP.COM FOR IMMEDIATE MRI SCHEDULING***