REFERRAL FORM

FAX: 702.873.4824

GE 1.5T MRI
3430 N. Buffalo Dr., #110
Las Vegas, NV 89129
Office Ph: 702.362.6652

ADVANTAGE DIAGNOSTIC imaging center

OPEN SIDED MRI
2980 S. Jones Blvd., #E
Las Vegas, NV 89146
Office Ph: 702.362.6652

☐ STAT Claustrophobia? ☐ Yes ☐ No Does patient need transportation? ☐ Yes ☐ No

PATIENT INFORMATION

Date: _____ Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ ZIP: _____

Cellular #: _____ Home #: _____ Other #: _____

REQUESTED APPOINTMENT INFORMATION

Requested Appointment Date: _____ Requested Appointment Time: _____

EXAMINATION REQUESTED

Type of Exam

- ☐ MRI (No Contrast)
- ☐ MRI w/Contrast
- ☐ MRI w/ & w/o Contrast
- ☐ Open Sided
- ☐ Gravity Simulated (lumbar only)
- ☐ X-ray _____ Please State Body Part

Body Part

- ☐ Brain/Head
- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar
- ☐ Pelvis
- ☐ Sacrum
- ☐ Other: _____ Please State Body Part
- ☐ Chest
- ☐ Breast
- ☐ Abdomen
- ☐ Pelvis
- ☐ Prostate
- ☐ Shoulder
- ☐ Elbow
- ☐ Wrist
- ☐ Hand
- ☐ Hip
- ☐ Knee
- ☐ Ankle
- ☐ Foot

Body Area

- ☐ Right
- ☐ Left
- ☐ Bilateral
- ☐ Upper
- ☐ Lower

INSURANCE INFORMATION

Method of Payment: ☐ Lien ☐ Third Party ☐ Auto Ins ☐ Workman's Comp ☐ Cash

Attorney Name: _____ Case Manager: _____ Phone #: _____

Auto Insurance / Third Party: _____ Phone #: _____ Date of Injury: _____

Name of Policy Holder: _____ Policy #: _____

REFERRING DOCTOR INFORMATION

Send: ☐ Report Only ☐ Films ☐ CD ☐ With Patient ☐ To Office

Doctor Name: _____ Dr. Signature: _____

Office Address: _____ City: _____ State: _____ ZIP: _____

Contact Person: _____ Office #: _____ Fax #: _____

Fax #: _____ NPI #: _____

CC: _____ Fax: _____

CC: _____ Fax: _____

Diagnosis Codes (ICD-10)

1 _____ 2 _____

3 _____ 4 _____

GE 1.5T MRI

OPEN SIDED MRI

SPANISH SPEAKING

Thank you very much for your referrals