

GE I.5T MRI

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



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

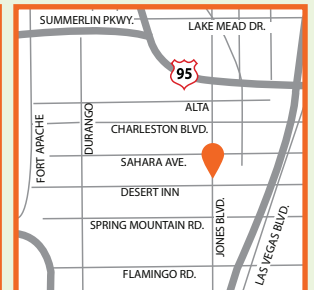
Doctor Name: _____ Dr. Signature: _____
Office Address: _____ City: _____ State: _____ ZIP: _____
Contact Person: _____ Office #: _____ Fax #: _____
Fax #: _____ NPI #: _____
CC: _____ Fax: _____
CC: _____ Fax: _____

Diagnosis Codes (ICD-10)

1 _____ 2 _____
3 _____ 4 _____



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