MRI IMAGING REFERRAL FORM

25 Riviera Blvd. Lake Havasu City, AZ 86403 Phone: 928.923.6658

Patient Information

Patient Name (as stated on insurance card): _____DOB: _____

Address: _____ City: _____ State: _____

Phone: _____ Email: _____

Insurance: _____ Insurance Phone #: _____

ID #: _____ Authorization #: _____

Clinical HX/DX and Special Instructions: _____

_____

No patients with pacemakers, aneurysm clips, foreign bodies in the eyes or cochlear implants

Provider Information

Referring Provider Name: _____ NPI: _____

Office Name: _____ Office Phone #: _____

Address: _____ City: _____ State: _____

Referring Provider Signature: _____

❒ Routine Fax: _____ ❒ **Stat Fax:** _____ ❒ **Stat Call:** _____

MRI W/O CONTRAST

❒ BRAIN/HEAD ❒ IAC ❒ PITUITARY
❒ ORBIT ❒ FACE ❒ SINUS ❒ NECK
❒ CERVICAL
❒ THORACIC
❒ LUMBAR ❒ LUMBAR PLEXUS ❒ RIGHT ❒ LEFT
❒ PELVIS ❒ SACRUM/COCCYX
❒ SI JOINTS
❒ CHEST ❒ MEDIUSTINUM
❒ ABDOMEN ❒ KIDNEY ❒ ADRENAL ❒ MRCP ❒ LIVER
❒ UPPER EXT NON JT ❒ FINGER ❒ THUMB ❒ HAND ❒ RIGHT ❒ LEFT
❒ FOREARM ❒ HUMERUS ❒ RIGHT ❒ LEFT
❒ UPPER EXT JOINT ❒ SHOULDER ❒ ELBOW ❒ WRIST ❒ RIGHT ❒ LEFT
❒ BRACHIAL PLEXUS ❒ RIGHT ❒ LEFT
❒ LOWER EXT NON JOINT ❒ FEMUR ❒ TIB/FIB ❒ MID FOOT ❒ RIGHT ❒ LEFT
❒ FOREFOOT/TOES ❒ RIGHT ❒ LEFT
❒ LOWER EXT JOINT ❒ HIP ❒ KNEE ❒ ANKLE/HEEL ❒ RIGHT ❒ LEFT