



**MRI**

Patient Name:		DOB:
Home Phone Number:	Work Phone:	Alternate Number:
Referring Physician:		Office Phone:
Physician's Address:		Fax #:
Clinical History:		
Is the patient diabetic?	Yes No	If yes, list medications:
Is the patient pregnant?	Yes No	Is the patient claustrophobic? Yes No
Physician Signature:		Date:

<b>MRI / MRA</b> <input type="radio"/> With Contrast <input type="radio"/> Without Contrast <input type="radio"/> Radiologist's Discretion		
<input type="checkbox"/> Brain <input type="checkbox"/> Orbits <input type="checkbox"/> IAC <input type="checkbox"/> Face (soft tissue) <input type="checkbox"/> TMJ <input type="checkbox"/> Neck (soft tissue) <input type="checkbox"/> Brachial Plexus <input type="checkbox"/> Pituitary <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacrum <input type="checkbox"/> MR Cholangiogram	<input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Liver <input type="checkbox"/> Pancreas <input type="checkbox"/> Kidney <input type="checkbox"/> Adrenal <input type="checkbox"/> Pelvis <input type="checkbox"/> Shoulder <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Elbow <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Wrist <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Hand <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Bony Pelvis <input type="checkbox"/> Hip <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Other _____	<input type="checkbox"/> Knee <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Ankle <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Foot <input type="checkbox"/> R <input type="checkbox"/> L MRI Other _____  <b>MRA</b> <input type="checkbox"/> Brain <input type="checkbox"/> Neck <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Lower Extremity <input type="checkbox"/> <b>Other Vascular</b> _____ _____
<b>Hours of Operation: Monday – Friday 7am – 10pm and Sunday 9am – 5pm</b>		

<b>Please call 718.758.1500 to schedule an appointment.</b>	
Appointment Date / Time: _____	Pre-Certification #: _____
Please have your insurance card available. <b>Please Note: Co-payments are collected at time of visit.</b>	