



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:

MRI / MRA			O With Contrast	O Without Contract	O Radiologist Discretion
<input type="checkbox"/> Brain	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Knee	<input type="checkbox"/> R	<input type="checkbox"/> L	
<input type="checkbox"/> Orbits	<input type="checkbox"/> Liver	<input type="checkbox"/> Ankle	<input type="checkbox"/> R	<input type="checkbox"/> L	
<input type="checkbox"/> IAC	<input type="checkbox"/> Pancreas	<input type="checkbox"/> Foot	<input type="checkbox"/> R	<input type="checkbox"/> L	
<input type="checkbox"/> Face (soft tissue)	<input type="checkbox"/> Kidney	<input type="checkbox"/> MRI Other _____			
<input type="checkbox"/> TMJ	<input type="checkbox"/> Adrenal	MRA			
<input type="checkbox"/> Neck (soft tissue)	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Abdomen			
<input type="checkbox"/> Brachial Plexus	<input type="checkbox"/> Breast	<input type="checkbox"/> Pelvis	<input type="checkbox"/> R	<input type="checkbox"/> L	
<input type="checkbox"/> CSF Flow Study Head	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Brain	<input type="checkbox"/> R	<input type="checkbox"/> L	
<input type="checkbox"/> Pituitary	<input type="checkbox"/> MR Arthrogram	<input type="checkbox"/> Neck	<input type="checkbox"/> R	<input type="checkbox"/> L	
<input type="checkbox"/> Cervical Spine	Shoulder	<input type="checkbox"/> Intracranial (Circle of Willis)			
<input type="checkbox"/> Thoracic	<input type="checkbox"/> MR Arthrogram Hip	<input type="checkbox"/> Extracranial (Common Carotid	<input type="checkbox"/> R	<input type="checkbox"/> L	
<input type="checkbox"/> Lumbar	<input type="checkbox"/> Elbow	Carotid Bifurcations)	<input type="checkbox"/> R	<input type="checkbox"/> L	
<input type="checkbox"/> Sacrum	<input type="checkbox"/> Wrist	<input type="checkbox"/> Lower Extremity	<input type="checkbox"/> R	<input type="checkbox"/> L	
<input type="checkbox"/> MR Cholangiogram	<input type="checkbox"/> Hand	<input type="checkbox"/> Other Vascular _____	<input type="checkbox"/> R	<input type="checkbox"/> L	
	<input type="checkbox"/> Bony Pelvis		<input type="checkbox"/> R	<input type="checkbox"/> L	
	<input type="checkbox"/> Hip		<input type="checkbox"/> R	<input type="checkbox"/> L	

Hours of Operation: Monday – Friday 8am – 10pm Sat & Sun 8am – 8pm

Please call 212.473.2300 to schedule an appointment.

Appointment Date / Time: _____ Pre-Auth #: _____
Please have your insurance card available. **Please Note: Co-payments are collected at time of visit.**