

APPOINTMENT DATE:
APPOINTMENT TIME:
ARRIVAL TIME:

FOR FAX SCHEDULING
Fax To: 761-8940



**Imaging Center
of Louisiana**

Baton Rouge

Scheduling Calls: 761-8988

PATIENT INFORMATION

Patient's Name: _____ Date of Birth _____

Diagnosis/History _____ S.S.# _____

Referring Physician Authorization: _____

Phone (H) _____ (W) _____ (Cell) _____

Has your patient ever had a previous study of this area?

If yes, where? _____ Which study was done? _____ How long ago? _____

Insurance _____

Phone # _____ Member # _____

Comments _____

MRI/MRA ORDER

- | | | | |
|--|--|--|------------------------------------|
| <input type="checkbox"/> MRI Abdomen __w__wo Contrast | <input type="checkbox"/> MRI Orbits __w__wo Contrast | <input type="checkbox"/> MRA Brain | <input type="checkbox"/> MRV Brain |
| <input type="checkbox"/> MRI Ankle __w__wo Contrast | <input type="checkbox"/> MRI Pelvic __w__wo Contrast | <input type="checkbox"/> MRA Neck | <input type="checkbox"/> MRA Other |
| <input type="checkbox"/> MRI Arm __w__wo Contrast | <input type="checkbox"/> MRI Pituitary __w__wo Contrast | <input type="checkbox"/> Cervical MYELOGRAM & CT | |
| <input type="checkbox"/> MRI Brain __w__wo Contrast | <input type="checkbox"/> MRI Shoulder __w__wo Contrast | <input type="checkbox"/> Thoracic MYELOGRAM & CT | |
| <input type="checkbox"/> MRI Cervical __w__wo Contrast | <input type="checkbox"/> MRI Soft Tissue Neck __w__wo Contrast | <input type="checkbox"/> Lumbar MYELOGRAM & CT | |
| <input type="checkbox"/> MRI Elbow __w__wo Contrast | <input type="checkbox"/> MRI Thoracic __w__wo Contrast | <input type="checkbox"/> Other MYELOGRAM & CT | |
| <input type="checkbox"/> MRI Finger __w__wo Contrast | <input type="checkbox"/> MRI TMJ __w__wo Contrast | | |
| <input type="checkbox"/> MRI Foot __w__wo Contrast | <input type="checkbox"/> MRI Wrist __w__wo Contrast | <input type="checkbox"/> CT, Specify Area _____ | _____ w__wo Contrast |
| <input type="checkbox"/> MRI Hand __w__wo Contrast | <input type="checkbox"/> MRI Other __w__wo Contrast | | |
| <input type="checkbox"/> MRI Hip __w__wo Contrast | <input type="checkbox"/> MRI Extremity __w__wo Contrast | <input type="checkbox"/> X-ray, Specify Area _____ | _____ w__wo Contrast |
| <input type="checkbox"/> MRI Knee __w__wo Contrast | <i>Specify Area</i> _____ | | |
| <input type="checkbox"/> MRI Leg __w__wo Contrast | | | |
| <input type="checkbox"/> MRI Lumbar __w__wo Contrast | <i>Specify Area</i> _____ | | |

Diagnosis: _____ Comments: _____

NOT ALLOWED IN MRI: Cardiac Pacemakers, Intracranial Aneurysm Clips, Metallic Foreign Bodies in Eyes

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We make it easier for you!