www.PrecisionMRIGroup.com

☐ Precision of Lake Worth	☐ Pines Imaging	☐ Cypress Creek MRI	☐ Precision of Port St. Lucie
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☐ Open MRI ☐ High Field MRI	☐ High Field MRI	☐ High Field MRI	☐ Open MRI

Patient Name: ______________________ (Last / First) SS#: ______________

☐ Male ☐ Female

Patient Address: ______________________ (Street / City / State / Zip)

Home Phone: __________ Work: __________ DOB: __________ (MM / DD / YYYY)

Insurance Company: ______________________ Claim #: ______________

Insurance Phone #: __________ Authorization #: __________ Policy #: __________

Date of Accident: __________ Attorney Name: __________ Attorney Ph #: __________

Reason for Exam: ______________________

Ordering Physician Name: ______________________

Is patient to receive disc? ☐ Yes ☐ No Is transportation needed? ☐ Yes ☐ No

MAGNETIC RESONANCE IMAGING

BRAIN:
- ☐ MRI Spectroscopy
- ☐ Brain
- ☐ IAC and Cranial Nerves
- ☐ Pituitary
- ☐ Para nasal/Sinuses

MRA:
- ☐ Carotid w/wo
- ☐ Cerebral w/o
- ☐ MRI Cgest/MRA/Thoracic
- ☐ Aorta w/wo
- ☐ MRI Abdomen/MRA
- ☐ AbdominalAortaw/wo
- ☐ MRIKidneyMRARenalsw/wo
- ☐ Runoff:Abdomen&Lower Extremitiesw/wo
- ☐ Other: ______________

SPINE:
- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar
- ☐ Sacrum/Coccyx

BODY:
- ☐ Soft Tissue Neck
- ☐ Brachia! Plexus
- ☐ Breast
- ☐ Chest
- ☐ Liver
- ☐ Pancreas
- ☐ Adrenal/Renal
- ☐ Pelvis
- ☐ Prostate
- ☐ Uterus/Ovaries

MUSCULOSKELETAL:

		L	R
☐	Shoulder	☐	☐
☐	Elbow	☐	☐
☐	Wrist	☐	☐
☐	Hand/Finger	☐	☐
☐	Hip	☐	☐
☐	Knee	☐	☐
☐	Ankle	☐	☐
☐	Foot	☐	☐
☐	Temporomandibular	☐	☐
☐	Other Musculoskeletal:	☐	☐

CONCUSSION
- ☐ Traumatic Brain Diagnostic test

CONTRAST:
- ☐ WITH
- ☐ WITHOUT

PATIENT APPOINTMENT

Date: ______________

Time: ______________

Patient Notification: ☐ Yes ☐ NO

REFERRAL FROM:

Referral phone: ______________

Email: ______________

REPORT/TURNAROUND
- ☐ Wet Read
- ☐ Radiologist Consult
- ☐ Routine (24-48 hours)

______________________ Physician's Signature

______________ Date

I hereby certify that the above request is medical necessary and furthermore give Precision Diagnostic permission to obtain all preauthorizations and/or benefit verification to schedule this patient on my behalf.

REV.: 10.28.2021