

Scheduled: Y / N / P  
 NPP Signed: Y / N  
 Prgris #: \_\_\_\_\_  
 Patient ID: \_\_\_\_\_  
 Previous Exam: Y / N / P  
 Reports attached: Y / N  
 PT Pre-registered: Y / N

# MRI Phone Confirmation

Patient Information Sheet (please print clearly)			
Exam Date:	Exam Time:	PT WEIGHT:	
Patients Name:			
Social Security #:	Date of Birth:	Home Phone:	Work Phone:
MRI Exam:		Referring M.D.:	
Diagnosis:			
*****When booking ankle/foot/wrist/hand/elbow pt needs to bring X-Rays for MRI Exam			
Is this a <b>work related accident</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No (see below)		Is this an auto related accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this a personal injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		DATE OF INJURY:	
<b>IF SELF PAY:</b> Inform patient to call Cheryl in billing office.			
Insurance Information			
Insurance Carrier:		Certificate #:	
Pre-cert #:		Medicaid #:	
WORKERS COMP INFO (if necessary)			
Carrier:		Address:	
Contact Person:		Phone #:	
Claim #:	Approved by:	Employer:	
Faxed to Cheryl <input type="checkbox"/> Date:	Time:	By:	

HISTORY QUESTIONS	YES	NO
Cardiac Pacemaker? (IF YES CANT DO EXAM)		
Brain aneurysm clip? (IF YES CANT DO EXAM)		
Infusion pump (insulin, chemotherapy)? (IF YES CANT DO EXAM)		
Metal fragment in eyes? Work with metal, grinding, under cars? <input type="checkbox"/> Patient sent for Orbit X-Rays Negative / Positive		
Possibility of pregnancy?		
Have you had brain, abdominal or heart surgery? If so, what type and when?		
If <b>LUMBAR SPINE SCAN</b> , have you had back surgery? If so, what type and when		