LOUISVILLE MRI

Phone (502) 380-3901
Fax (502) 380-3902

EIN:46-1834026

Patient Name: _____
Last First

O Male O Female

Patient Address: _____
Street City State Zip

Home Phone: _____ Cell: _____ DOB: _____
MM/DD/YYYY

Insurance Company: _____ Claim#: _____

Insurance Phone #: _____ Authorization #: _____ Policy #: _____

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

Reason for Exam: _____

Ordering Physician: _____

Is patient to receive films? O Yes O No **Is transportation needed?** O Yes O No

Is patient to receive CD? O Yes O No

MAGNETIC RESONANCE IMAGING

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

MRA:
O Carotid w/wo
O Cerebral w/wo
O MRI Cgest/MRA/Thoracic
O Aorta w/wo
O MRI Abdomen/MRA
O Abdominal Aorta w/wo
O MRI Kidney MRA Renals w/wo
O Runoff: Abdomen & Lower Extremities w/wo
O Other: _____

SPINE:
O Cervical
O Thoracic
O Lumbar
O Sacrum/Coccyx

BODY:
O Soft Tissue Neck
O Brachial Plexus
O Breast
O Chest
O Liver
O Pancreas
O Adrenal/Renal
O Pelvis
O Prostate
O Uterus/Ovaries

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

CONTRAST:
O With
O Without

PATIENT APPOINTMENT
Date: _____
Time: _____
Patient Notified: O Yes O No

_____
Physician's Signature

I hereby certify that the above request is medically necessary and furthermore give MRI of Louisville permission to obtain all preauthorizations and/or benefit verification needed to schedule this patient on my behalf.