

6576 Airport Boulevard | Mobile, Alabama 36608 • Phone: 251.460.4112 • Fax: 251.460.4590
Tax ID: #62-1664765 • NPI: #1548228323



PHYSICIAN REFERRAL FORM

Patient's name: _____ DOB: _____ Appt. Date: _____ Time: _____

Mobile #: _____ Alternate #: _____ Pre-Certification Number (if required): _____

Insurance Information: _____ # _____

Clinical indications/Signs/Symptoms: _____

MRI	CT	ARTHROGRAMS
CONTRAST: <input type="radio"/> without <input type="radio"/> with only <input type="radio"/> with and without <input type="radio"/> Radiologist Discretion		<input type="radio"/> MRI Arthrogram Joint:
<input type="radio"/> Brain <input type="radio"/> IACs <input type="radio"/> Pituitary/Sella <input type="radio"/> Orbits <input type="radio"/> TMJ <input type="radio"/> Soft Tissue Neck (structures other than C-Spine) <input type="radio"/> Brachial Plexus <input type="radio"/> Spine <input type="checkbox"/> C-Spine <input type="checkbox"/> T-Spine <input type="checkbox"/> L-Spine <input type="radio"/> Pelvis <input type="radio"/> Abdomen (specify) <input type="radio"/> Hip - R L <input type="radio"/> Hips - Bilateral <input type="radio"/> Extremity <input type="checkbox"/> Ankle <input type="checkbox"/> Elbow <input type="checkbox"/> Foot <input type="checkbox"/> Knee <input type="checkbox"/> Wrist <input type="checkbox"/> Shoulder <input type="radio"/> Other: _____	<input type="radio"/> Abdomen <input type="radio"/> Abdomen/Pelvis <input type="radio"/> Brain <input type="radio"/> Cervical Spine <input type="radio"/> Limited Study <input type="radio"/> Lower Extremity <input type="radio"/> Lumbar Spine <input type="radio"/> Neck, Soft Tissue <input type="radio"/> Orbits <input type="radio"/> Pelvis <input type="radio"/> Sinus <input type="radio"/> Sinus, Limited <input type="radio"/> Thoracic Spine <input type="radio"/> Urogram <input type="radio"/> Upper Extremity <input type="radio"/> Other: _____	<div style="background-color: #c00000; color: white; text-align: center; padding: 2px;">ULTRASOUND</div> <input type="radio"/> Abdomen, complete <input type="radio"/> Abdomen, limited (e.g. RUQ): _____ <input type="radio"/> Carotid <input type="radio"/> Extremity (Including Doppler) <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Arterial R L Bilat <input type="checkbox"/> Venous R L Bilat <input type="checkbox"/> Soft tissue R L Bilat <input type="radio"/> Pelvis/Transvaginal <input type="radio"/> OB 13 wks or less <input type="radio"/> OB 14 wks or more <input type="radio"/> Renal/Bladder <input type="radio"/> Renal Arterial w/Color Doppler <input type="radio"/> Scrotum w/Color Doppler <input type="radio"/> Thyroid <input type="radio"/> Transplant w/Color Doppler <input type="radio"/> Other: _____
MR Angiography <input type="radio"/> Brain (COW) <input type="radio"/> Neck (Carotid) <input type="radio"/> Chest (Aorta) <input type="radio"/> Abdomen (Aorta/Mesenteric/Renal) <input type="radio"/> Abdomen and Pelvis <input type="radio"/> Pelvis and Lower Extremities (Run-off) <input type="radio"/> MR Venography: _____	Chest <input type="radio"/> Routine <input type="radio"/> PE <input type="radio"/> Cardiac Calcium Scoring	<div style="background-color: #c00000; color: white; text-align: center; padding: 2px;">COMPARISON STUDIES</div> Location: _____ _____
	CT Angiography <input type="radio"/> Brain (COW) <input type="radio"/> Neck (Carotid) <input type="radio"/> Chest (Aorta) <input type="radio"/> Abdomen (Aorta/Mesenteric/Renal) <input type="radio"/> Abd/Pelvis <input type="radio"/> Aorta w/run-off <input type="radio"/> CT Venography: _____	<div style="background-color: #c00000; color: white; text-align: center; padding: 2px;">REPORT DELIVERY</div> <input type="radio"/> STAT Cell or backline: _____ <input type="radio"/> Call Report Cell or backline: _____
	<div style="background-color: #c00000; color: white; text-align: center; padding: 2px;">PERFORM 3-D /MULTI-PLANE RECONSTRUCTIONS:</div> If necessary <input type="radio"/> Yes <input type="radio"/> No	<div style="background-color: #f0e68c; text-align: center; padding: 2px;">Standard report in 24-48 hours.</div>

Provider name (printed): _____ Provider signature: _____

Office phone: _____ Fax: _____ Date: _____

PATIENT INSTRUCTIONS

BRING THIS ORDER WITH YOU TO YOUR SCHEDULED EXAM • CAREFULLY FOLLOW EXAM PREPARATION INSTRUCTIONS BELOW.
VISIT US ONLINE AT www.MRIofAL.com FOR DRIVING DIRECTIONS AND TO LEARN MORE ABOUT OUR IMAGING FACILITY AND SERVICES.

Center Information

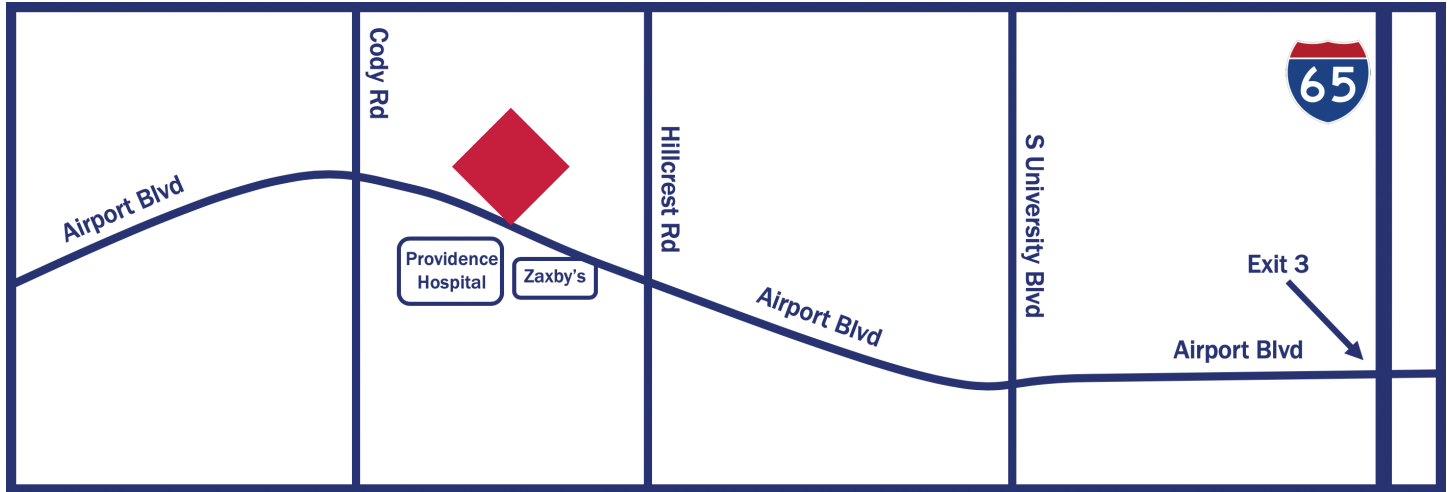
Mobile Open MRI & Imaging

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CT (Computed Tomography)

CT Scans of the Abdomen or Pelvis: No solid food from midnight the night before. Drinking of clear liquids is encouraged. If your test is scheduled later in the day, please contact the office for different instructions.

- Drink one (1) full bottle of contrast at bedtime the night before.
- Drink half (1/2) a bottle of contrast 1 hour prior to exam.
- Drink half (1/2) of the remaining bottle on the CT table just before the test.
- Take routine medications as usual.

Other CT exams: Clear liquids only for four (4) hours prior to exam.

Ultrasound

Abdomen, Right Upper Quadrant, Renal and Aorta:

- Nothing to eat or drink after midnight or 6 hours prior to exam.

Pelvis

- Full bladder required. All must drink 32 oz. of water 1 hour prior to exam (if on a fluid restricted diet, please contact the office for other instructions).

MRI (Magnetic Resonance Imaging)

Our office will contact you 24 hours before your appointment to confirm your appointment and provide prep instructions.

Let us know if you have:

- Metallic fragments in your eyes or previous injury to the eye involving a metal object
- Any type of implanted mechanical pump
- Any type of surgery within the past 8 weeks
- A history of cancer
- A pacemaker
- An aneurysm clip
- Any metallic implant

Let us know if you are:

- Allergic to CT or MRI contrast
- Claustrophobic
- Pregnant/nursing
- In need of special assistance

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