



MRI/MRA  
Multi Slice C.T.  
Digital X-Ray  
NCV/EMG Studies  
dx Ultrasound

Also offering: Flexion/Extension and Weight Bearing MRI studies

Please fill out completely and fax both *referral form and insurance information* to **510-223-5125**.

**PLEASE NOTE: bolded information is required.**

Today's Date:	<b>Patient Pregnant:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Patient Name:</b>	<input type="checkbox"/> M <input type="checkbox"/> F
<b>Home Phone:</b>	Work Phone:
Alternate Phone:	<b>DOB:</b>
<b>Referring Physician:</b>	<b>SSN:</b>
Physician Phone:	Physician Fax:
Reason for Exam:	<b>ICD 9 Code(s):</b>
<b>Date of Injury (if applicable):</b>	<b>STAT READ:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>ORBITS screening needed:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Image Request:</b> FILM <input type="checkbox"/> CD <input type="checkbox"/> None <input type="checkbox"/>

**INSURANCE INFORMATION (REQUIRED)**

<b>Insurance Company:</b>	<b>Authorization Initiated?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Insurance ID#:</b>	<b>Authorization # (if obtained):</b>

**PROCEDURE INFORMATION (REQUIRED)**

MRI <input type="checkbox"/> with contrast <input type="checkbox"/> Weight Bearing <input type="checkbox"/> Flexion/Extension	CT Scan <input type="checkbox"/> with Contrast	X-Rays <input type="checkbox"/> Flexion/Extension	Ultrasound
<input type="checkbox"/> <b>OPEN MRI PREFERRED</b>	<input type="checkbox"/> 72125 Cervical Spine	<input type="checkbox"/> Sinus Series	<input type="checkbox"/> Abdomen
<input type="checkbox"/> 72141 Cervical Spine	<input type="checkbox"/> 72131 Lumbar Spine	<input type="checkbox"/> Chest (_____ views)	<input type="checkbox"/> Thyroid
<input type="checkbox"/> 72148 Lumbar Spine	<input type="checkbox"/> 72128 Thoracic Spine	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Carotid (vascular)
<input type="checkbox"/> 72146 Thoracic Spine	<input type="checkbox"/> Chest	<input type="checkbox"/> Hips R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/> Pelvis
<input type="checkbox"/> 70547 Neck (soft Tissue)	<input type="checkbox"/> 73200 Shoulder R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/> Spine	<input type="checkbox"/> Testicular
<input type="checkbox"/> 71550 Chest	<input type="checkbox"/> 73700 Knee R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Retroperitoneum
<input type="checkbox"/> 73221 Shoulder R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/> 73700 Ankle R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> Bladder
<input type="checkbox"/> 73721 Knee R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/> Sinuses <input type="checkbox"/> Limited Sinuses	<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/> Aorta
<input type="checkbox"/> 73721 Ankle R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/> 72192 Pelvis	<input type="checkbox"/> Spine	<input type="checkbox"/> Breast
<input type="checkbox"/> 73221 Wrist R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/> 74150 Abdomen	<input type="checkbox"/> Upper Extremity R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/> Obstetric
<input type="checkbox"/> 73221 Extremity R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/> 70460 Head or Brain	(note extremity _____)	<input type="checkbox"/> Venous Extremity
<input type="checkbox"/> 73721 Hips R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/> Lower Extremity R <input type="checkbox"/> L <input type="checkbox"/>	(specify _____)
<input type="checkbox"/> 72195 Pelvis	<input type="checkbox"/> Dental Series	(note extremity _____)	<input type="checkbox"/> Other
<input type="checkbox"/> 70551 Head or Brain	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	(specify _____)
<b>MRA</b> <input type="checkbox"/> 73725 with contrast			<b>EMG/NCV Studies</b>
<input type="checkbox"/> Head <input type="checkbox"/> Neck			Upper R <input type="checkbox"/> L <input type="checkbox"/>
			Lower R <input type="checkbox"/> L <input type="checkbox"/>
<b>Claustrophobic?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No • Bring any previous x-rays with you • Bring insurance cards with you. • Co-payment or deductible is expected at the time of service. • Notify the technologist if you think you are pregnant or you might be, or if you are breast-feeding.		<b>Special Requests/Comments:</b>	
<b>Physician's Signature (required):</b>			

**2970 Hilltop Mall Rd. #103  
Richmond, CA 94806**

**Phone: 510-223-5122  
Fax: 510-223-5125**