OPEN MRI of Macon

Hardeman Avenue at I - 75

openmriofmacon.com

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PHYSICIANS ORDER

Saturday & Extended Evening Hours

ACR Accredited

Let us Pre-Cert for you!

Patient Name:_____ DOB:_____/_____/_____ Weight:_____lbs.

Patient Contact #: (_____) _____ - _____ Patient Alt. #: (_____) _____ - _____ Male / Female

Referring Physician: _____ Phone #:_____

Based on the patient's history, exam and diagnosis, I have requested the below listed exam(s). I hereby certify that the exam(s) are medically necessary.

REFERRING PHYSICIAN SIGNATURE:_____NPI #:_____Date:_____/_____/_____

Appointment Date: _____ Appointment Time: _____

☐ STAT Call Report to: (_____) _____ - _____ ☐ FAX Report to: (_____) _____ - _____

MRI 1.5 Tesla High Field

CONTRAST: ☐ **YES** ☐ **NO**

☐ **BRAIN**
- ☐ WITH ORBITS ☐ WITH IAC'S
- ☐ WITH PITUITARY / SELLA

☐ BRACHIAL PLEXUS

☐ SOFT TISSUE NECK ☐ TMJ

☐ **MRA**
- ☐ HEAD wo ☐ NECK w / wo
- ☐ RENAL w / wo
- ☐ AORTIC ARCH w / wo
- ☐ MRV w / wo

☐ CERVICAL SPINE ☐ MYELOGRAM SEQUENCE

☐ THORACIC SPINE ☐ MYELOGRAM SEQUENCE

☐ LUMBAR SPINE ☐ MYELOGRAM SEQUENCE

☐ SACRUM ☐ COCCYX

☐ SHOULDER ☐ L ☐ R

☐ SCAPULA ☐ L ☐ R

☐ HUMERUS ☐ L ☐ R

☐ ELBOW ☐ L ☐ R

☐ FOREARM ☐ L ☐ R

☐ WRIST ☐ L ☐ R

☐ HAND ☐ L ☐ R

☐ HIP ☐ L ☐ R

☐ FEMUR ☐ L ☐ R

☐ LOWER LEG ☐ L ☐ R

☐ KNEE ☐ L ☐ R

☐ ANKLE ☐ L ☐ R

☐ FOOT ☐ L ☐ R

☐ PELVIS- SOFT TISSUE ☐ PELVIS- BONY

☐ **ABDOMEN**
- ☐ MRCP ☐ LIVER ☐ PANCREAS
- ☐ RENAL ☐ ADRENALS

☐ **OTHER** _____

INSURANCE INFORMATION

Primary Ins.:_____

Patient ID#:_____Group#:_____

Pre-Authorization #: _____

Secondary Ins.:_____

Patient ID#:_____Group#:_____

Pre-Authorization #: _____

SPECIALTY MRI EXAMS

☐ SMALL BOWEL w / wo ☐ FISTULA w / wo

☐ PROSTATE w / wo ☐ FEMALE PELVIS w / wo

☐ RECTUM w / wo

ULTRASOUND

GENERAL

☐ AAA ABDOMINAL AORTIC ANEURYSM

☐ ABDOMINAL COMPLETE

☐ ABDOMINAL LIMITED

☐ PELVIC (COMPLETE)

☐ PELVIC (TRANSVAGINAL)

☐ RENAL

☐ SCROTAL / TESTICULAR

☐ SOFT TISSUE NECK

☐ SOFT TISSUE EXTREMITY

☐ THYROID

VASCULAR

☐ CAROTID COMPLETE

☐ EXTREMITY ARTERIAL DOPPLER COMPLETE U / L

☐ EXTREMITY ARTERIAL DOPPLER LIMITED U / L

☐ EXTREMITY VEINS COMPLETE

☐ EXTREMITY VENOUS DOPPLER COMPLETE U / L

☐ EXTREMITY VENOUS DOPPLER LIMITED U / L

☐ OTHER_____

DIAGNOSIS CODE

_____ _____

_____ _____

_____ _____

Please fax this completed form to: 478-745-3136