OPEN MRI of Tifton

www.openmrioftifton.com

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PHYSICIANS ORDER

Monday - Saturday

Extended Evening Hours

Let us Pre-Cert for you!

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

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

MRI Exam Date/Time: _____ Physician Follow Up: _____

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 #:_____Tax ID:_____

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

MRI

CONTRAST: ☐ YES ☐ NO

BRAIN / NECK

- ☐ BRAIN
- ☐ ORBITS
- ☐ IAC'S
- ☐ PITUITARY
- ☐ SOFT TISSUE NECK
- ☐ BRACHIAL PLEXUS

SPINE

- ☐ CERVICAL SPINE
- ☐ THORACIC SPINE
- ☐ LUMBAR SPINE
- ☐ SACRUM
- ☐ COCCYX

MRA

- ☐ HEAD (COW)
- ☐ NECK / CAROTID w / wo
- ☐ MRV w / wo

ABDOMEN / PELVIS

- ☐ LIVER
- ☐ RENAL
- ☐ ADRENALS
- ☐ PANCREAS
- ☐ PELVIS- BONY
- ☐ PELVIS- SOFT TISSUE
- ☐ PROSTATE
- ☐ OTHER _____
- ☐ OTHER _____

EXTREMITY

☐ 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
☐ KNEE	☐ L	☐ R
☐ LOWER LEG	☐ L	☐ R
☐ ANKLE	☐ L	☐ R
☐ FOOT	☐ L	☐ R
☐ OTHER _____		

PATIENT HISTORY

Does the patient have a history of any of the following:

- ☐ PACEMAKER
- ☐ ANEURYSM CLIPS
- ☐ CURRENTLY PREGNANT
- ☐ SURGERY WITHIN THE LAST 6 WEEKS
- ☐ IMPLANTED DEVICES

DIAGNOSIS CODE

CD with patient? ☐ Y ☐ N

_____ _____

_____ _____

_____ _____

INSURANCE INFORMATION

(May send copies of card or demographic sheet)

Primary Ins.:_____

Pt ID#:_____ Grp#:_____

Pre-Auth #: _____

Secondary Ins.:_____

Pt ID#:_____ Grp#:_____

Pre-Auth #: _____

Please fax this completed form to: 229-387-6791