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PRIORITYMRI
PUT YOUR HEALTH FIRST

# MRI REQUISITION

**Please complete all 3 parts and submit by email or fax**

## PART 1 PATIENT AND PHYSICIAN INFORMATION

**PATIENT NAME:**
Last | First | Middle

**REFERRING PHYSICIAN NAME:**
Billing #

**ADDRESS:**

**ADDRESS:**

**PHONE:** Home | Other

**PHONE:**

**EMAIL:**

**FAX:**

**DATE OF BIRTH:** MM/DD/YYYY

**SEX:** ☐M ☐F

**Additional Copies to:**

**PHN:**

**WEIGHT:**

## PART 2 MEDICAL

**MRI EXAM REQUESTED:**

Please provide details such as: Spinal Levels, L/R side etc.

**CLINICAL HISTORY:**

## PART 3 PATIENT SCREENING

| | |
|---|---|
| Cardiac Pacemaker or Defibrillator | Yes / No |
| Cerebral Aneurysm Clip | Yes / No |
| Internal Electrodes or Wires | Yes / No |
| Eye or Ear Implant | Yes / No |
| Metallic Orbital Foreign Body | Yes / No |
| Shrapnel or Bullet | Yes / No |
| Intravascular Coil, Stent or Filter | Yes / No |
| Breast Tissue Expander | Yes / No |
| Infusion Pump or Stimulator | Yes / No |
| Other: | Yes / No |
| Is the Patient Pregnant? | Yes / No |
| Is the Patient Breastfeeding? | Yes / No |
| Is the Patient Claustrophobic? | Yes / No |

**RELEVANT PRIOR EXAMS:** (e.g. MRI, CT, Nuc Med, X-Ray, Angiogram, Other)

**PHYSICIAN SIGNATURE:**