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## MRI REQUISITION

Please complete all 3 parts and submit by email or fax

PART 1 PATIENT AND PHYSICIAN INFORMATION		
<b>PATIENT NAME:</b> <small>Last                      First                      Middle</small>		<b>REFERRING PHYSICIAN NAME:</b>  Billing #
<b>ADDRESS:</b>		<b>ADDRESS:</b>
<b>PHONE:</b> Home                      Other		<b>PHONE:</b>
<b>EMAIL:</b>		<b>FAX:</b>
<b>DATE OF BIRTH:</b> yyyy/mm/dd <small>MM/DD/YYYY</small>		<b>Additional Copies to:</b>
<b>SEX:</b> <input type="checkbox"/> M <input type="checkbox"/> F		
<b>PHN:</b>	<b>WEIGHT:</b>	
PART 2 MEDICAL		PART 3 PATIENT SCREENING
<b>MRI EXAM REQUESTED:</b> Please provide details such as: Spinal Levels, L/R side etc.		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
<b>CLINICAL HISTORY:</b>		
<b>RELEVANT PRIOR EXAMS:</b> (e.g. MRI, CT, Nuc Med, X-Ray, Angiogram, Other)		
<b>PHYSICIAN SIGNATURE:</b>		