Glendale MRI INSTITUTE

624 S. Central Ave. • Glendale, CA 91204
(818) 241-3369 • fax (818) 242-0640
www.glendalemri.com

Patient's Name ______________________ Date ____________

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Date of Birth ____________ Weight ____________ Height ____________ Sex ________

Appointment Date/Time ______________________

REFERRING PHYSICIAN PLEASE CHECK BOX TO INDICATE DESIRED TEST.

MRI

☐ High Field 1.5 Tesla
☐ Open .35 Tesla
☐ With Contrast
☐ Without Contrast
☐ Right
☐ Left
☐ Arthrogram

Head
☐ Brain
☐ Pituitary
☐ Soft Tissue Neck
☐ IACS
☐ Orbits
☐ Face
☐ TMJ

Spine
☐ Cervical
☐ Thoracic
☐ Lumbar
☐ Sacrum
☐ Coccyx

Other
____

Extremity
☐ Knee
☐ Shoulder
☐ Hip
☐ Foot
☐ Elbow
☐ Ankle
☐ Wrist

Body
☐ Breast (Bilateral)
☐ Abdomen
☐ MRCP
☐ Pelvis
☐ Chest

MRA

☐ Brain (Cerebral)
☐ Neck (Carotid/Vertebral)
☐ Renal
☐ Aorta
☐ Run Off (Lower Extremity)
☐ Other ____________

Ultrasound

☐ Vascular (Please specify) ____________
☐ Abdomen (Please specify) ____________
☐ Pelvis (Please specify) ____________

☐ Other ______________________

Bone Densitometry (No preparation required. Please wear clothing without metal below the waist.)

☐ Osteoporosis Screening

PET

☐ Whole Body
☐ Neurology
☐ Melanoma

Please provide medical necessity for exams, i.e. clinical history, laboratory, pathology, x-ray reports.

Patient's Primary Care Physician ______________________

CT

☐ With IV Contrast
☐ Without IV Contrast

☐ Brain
☐ Chest
☐ Abdomen
☐ Pelvis

☐ Extremity ____________
☐ Spine ____________
☐ Other ____________

If the patient is over 60 years old or has risk for kidney disease (diabetes, hypertension, etc.), please attach recent labs for BUN and Creatinine.

Diagnosis/Symptoms

____

Referring Doctor Signature ____________ Phone ____________ Fax ____________

Please fax this form to Glendale MRI Institute at 818-242-0640 for appointment scheduling.

Reports

☐ Call Report
☐ Fax Typed Report
☐ Fax Preliminary Report

Films

☐ Patient to Wait for Film
☐ Send All Films Routine
☐ Send Films Only If Positive
☐ No Film Copies

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