TUCKAHOE ORTHOPAEDIC MRI CENTER
1501 MAPLE AVENUE, SUITE 103
RICHMOND, VIRGINIA 23226

MRI REQUEST

SCHEDULING - (804) 285-2300 EXT. 191
FAX (804) 527-2769

MRI APPOINTMENT DATE: ___/____/___
TIME: _____ am pm

PATIENT INFORMATION (PRINT)

Patient's Name _____ Date of Birth _____ /_____ /_____
First M.I. Last

Phone: (_____)_____ Work: (_____)_____ Cell: (_____)_____

Diagnosis _____

Insurance Carrier _____ Referral/Authorization #: _____
(Attach Front & Back Copy of Insurance Card)

Referring Physician _____ Physician Office Contact _____

Phone (_____) _____ Fax (_____)_____

PRE-MEDICAL SCREENING PRIOR TO SCHEDULING PATIENT'S MRI

1. Does patient have a pacemaker, aneurysm clip, implanted neurostimulator, or inner ear implants? Yes ☐ No ☐
2. Is the patient pregnant? Yes ☐ No ☐
3. Has the patient worked with metal professionally or as a hobby (grinding, fabricating)? Yes ☐ No ☐
4. Has the patient ever had a metallic object in their eye? Yes ☐ No ☐
5. Has the patient ever had liver or kidney disease / liver or kidney transplant? Yes ☐ No ☐
6. Does the patient's weight exceed 300 1bs.? Yes ____ No ____ If yes, patient's weight _____

TYPE OF MRI REQUESTED

☐ Brain
- ☐ MRA
- ☐ Brain
- ☐ Carotids

☐ Brachial Plexus
☐ Spine
- ☐ C-Spine
- ☐ T-Spine
- ☐ L-Spine

☐ IAC's / 7th and 8th Nerve
☐ Pituitary / Sella
☐ Orbits
☐ Soft Tissue Neck
☐ Pelvis
☐ Abdomen (Specify)

☐ Hip - ☐R / ☐L
☐ Extremity
- ☐ Ankle ☐R / ☐L
- ☐ Elbow ☐R / ☐L
- ☐ Foot ☐R / ☐L
- ☐ Hand ☐R / ☐L
- ☐ Knee ☐R / ☐L
- ☐ Shoulder ☐R / ☐L
- ☐ Wrist ☐R / ☐ L
- ☐ Other (Specify) _____

_____
_____

REFERRING PHYSICIAN REQUEST

Send CD of MRI with Patient: ☐
or
Send CD of MRI to Ordering Physician ☐

Mail to:
_____
_____
_____
_____

_____

Physician's Signature (Required) **Date**