



SOUTH BAY PREMIER MRI

PRECISION • COMFORT • CONFIDENCE

Siemens Espree • Wide Bore • AI-Enhanced 3T-quality imaging

MRI REQUEST / REFERRAL

29000 S. Western Ave, Suite 102

Rancho Palos Verdes, CA 90275

Tel: 310-598-2798 • Fax: 310-491-0691

info@SouthBayPremierMRI.com

Important Info:

- INSURANCE: Send demographics + insurance card WITH THIS REFERRAL **OR** complete the insurance section.
- DOCTOR SIGNS THE FRONT AND BACK.
- Complete all other sections.
- PAGE 2: Send clinical notes WITH THIS REFERRAL OR complete Page 2.
- FAX THIS REFERRAL + ALL ATTACHMENTS TO 310-491-0691.

01 PATIENT

Name _____ DOB _____ ☐ M ☐ F

Address _____

Best phone _____ Alt / emergency _____ Email _____

Insurance Company: _____ Member / ID #: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____ Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Authorization /case #: _____ ☐ Cash / self-pay ☐ WC / PI

Provider _____ NPI _____ Office phone _____

Practice _____ Fax reports to _____ Order date _____

02 SCHEDULING

Urgency: ☐ Soonest available / non-emergent ☐ Urgent 48–72h ☐ STAT / same-day if available

Preferred Appt Days: ☐ ANY DAY ☐ M ☐ T ☐ W ☐ Th ☐ F ☐ Sa ☐ Su Preferred Time: ☐ ANY TIME ☐ AM ☐ PM

Claustrophobic: ☐ Yes ☐ No ☐ Unknown ☐ Interpreter needed Language _____

03 EXAMINATION — CIRCLE L OR R (IF APPLICABLE)

☐ Brain	☐ Pelvis
☐ Brain — IAC / pituitary / orbits	☐ Hip L / R
☐ Head / face / TMJ	☐ Thigh / femur L / R
☐ C-spine	☐ Knee L / R
☐ T-spine	☐ Tibia–fibula L / R
☐ L-spine	☐ Ankle L / R
☐ Total spine (C/T/L)	☐ Foot / toes L / R
☐ Sacrum / coccyx	☐ SI joints
☐ Neck / thyroid / soft tissue	☐ Chest / mediastinum
☐ Brachial plexus L / R	☐ Abdomen
☐ Shoulder L / R	☐ MRCP
☐ Humerus L / R	☐ Prostate
☐ Elbow L / R	☐ Full-body vitality scan (4-region)
☐ Forearm L / R	☐ Other _____
☐ Wrist L / R	☐ Send prior discs / PACS
☐ Hand / fingers L / R	

04 MRI SAFETY / PATIENT SCREENING

Does the patient have a Pacemaker? ☐ Yes ☐ No Any known allergies to Iodine or MRI Contrast Dye? ☐ Yes ☐ No ☐ Unsure

Does the patient have Metal Implants? ☐ Yes ☐ No Internal Metal Leads / Spinal Stimulators? ☐ Yes ☐ No

Does the patient have Breast Implants? ☐ Yes ☐ No Does the patient work with or around metal? ☐ Yes ☐ No
(If yes, orbital X-rays required: We can schedule.)

05 PROTOCOL, CONTRAST, INDICATION

Contrast ☐ Without ☐ With ☐ With & without ☐ Radiologist protocol ☐ Arthrogram

ICD-10 / working diagnosis _____

Clinical indication (required) _____

Prior MRI on body part requested? Yes / No Date: _____

06 AUTHORIZATION

I certify this study is medically necessary. Please perform the MRI and send the report to my office.

Signature _____ Print name _____ Date _____

STAMP



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IF CLINICAL NOTES ARE ATTACHED: Write "SEE ATTACHED."

IF CLINICAL NOTES ARE NOT ATTACHED: Complete Page 2 to the best of your ability. Sign, date & stamp.

A PATIENT

Name _____ DOB _____ Date _____

B CHIEF COMPLAINT / HISTORY

C MECHANISM OF INJURY

D EXAMINATION FINDINGS

Sensation	☐ Normal	☐ Abnormal	Describe _____
Strength	☐ Normal	☐ Abnormal	Describe _____
Reflexes	☐ Normal	☐ Abnormal	Describe _____
Gait / coordination	☐ Normal	☐ Abnormal	Describe _____
Palpation / ROM	☐ Normal	☐ Abnormal	Describe _____

E SPECIAL TESTS

Test _____	☐ +	☐ -	Notes _____
Test _____	☐ +	☐ -	Notes _____
Test _____	☐ +	☐ -	Notes _____
Test _____	☐ +	☐ -	Notes _____

F OBJECTIVE SIGNS

☐ Swelling ☐ Bruising ☐ Limited ROM ☐ Deformity ☐ Instability ☐ Neuro deficit VAS 0-10 _____

G CONSERVATIVE CARE ALREADY TRIED

☐ PT ☐ Chiropractic ☐ Meds / NSAIDs ☐ Injections ☐ Home exercise ☐ Bracing ☐ Activity modification
Duration _____ Response _____

Has the patient completed 6 weeks of conservative care? ☐ Yes ☐ No

H MEDICAL NECESSITY — WHY MRI NOW

I ADDITIONAL NOTES

Signature _____ Print / credentials _____ Date _____

Signature confirms the above is accurate and the requested MRI is medically indicated.

STAMP