SOUTH BAY PREMIER MRI
29000 Western Ave, Suite 102 • Rancho Palos Verdes, CA 90275
Phone: (310) 555-1234 • Fax: (310) 555-5678 • info@southbaypremier.com

Did you just get hurt? Is it a weird time of day or night? No worries — we can likely see you.
Please text or call our emergency number: (310) 555-9999

1. Patient Information

Patient Name: _____ DOB: _____ Gender: [ ] M [ ] F [ ] Other
Address: _____
Best Contact #: _____ Emergency #: _____
Insurance / Policy #: _____
Referring MD / NPI #: _____

2. Appointment Details

Requested Date: _____ Preferred Time: [ ] AM [ ] PM [ ] Anytime Urgency: [ ] Routine [ ] Urgent [ ] Emergency
On-Call Request + Time: _____

3. MRI Procedure Details

Circle one: Right Left *(if applicable)*

[ ] Brain
[ ] Head / Face / Jaw
[ ] Neck / Thyroid
[ ] Sacrum
[ ] Pelvis
[ ] Humerus
[ ] Forearm
[ ] Hand
[ ] Cervical Spine
[ ] Thoracic Spine
[ ] Lumbar Spine
[ ] Coccyx
[ ] Shoulder
[ ] Elbow
[ ] Wrist
[ ] Hip
[ ] Thigh / Femur
[ ] Knee
[ ] Shin / Tibia–Fibula
[ ] Ankle
[ ] Foot
[ ] Visceral Organs: _____
[ ] Other: _____

4. Claustrophobia

Is the patient claustrophobic? (Circle one) Yes No Unsure

5. Additional MRI Details

Specific Area: _____ Contrast Required: [ ] Yes [ ] No Type: _____
Special Instructions: _____
Previous MRI/CT: _____
Diagnosis: _____

6. Signatures

Patient Consent & Authorization Signature / Date: _____
Referring Physician Print Name / Signature / Date: _____

7. For Office Use Only

Scheduled Appointment — Date / Time: _____ Study Complete — Date / Time / Tech Initials: _____
Tech Notes: _____

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1. Patient Info
Patient Name: _____ Date: _____

2. Symptoms / History
_____
_____

3. Physical Exam & Clinical Findings
Sensation: [ ] Normal [ ] Abnormal Description: _____
Strength: [ ] Normal [ ] Abnormal Description: _____
Reflexes: [ ] Normal [ ] Abnormal Description: _____
Gait / Coordination: [ ] Normal [ ] Abnormal Description: _____
Palpation: [ ] Normal [ ] Abnormal Description: _____

4. Mechanism of Injury
_____
_____

5. Orthopedic / Special Tests
Test Name: _____ [ ] + [ ] – Description: _____
Test Name: _____ [ ] + [ ] – Description: _____
Test Name: _____ [ ] + [ ] – Description: _____
Test Name: _____ [ ] + [ ] – Description: _____

6. Objective Findings / VAS
[ ] Swelling [ ] Bruising [ ] Limited ROM [ ] Deformity [ ] Instability VAS (0–10): _____

7. Treatment History / Conservative Care
[ ] Physical Therapy [ ] Medications [ ] Injections [ ] Chiropractic [ ] Home Exercise [ ] Other
Duration: _____ Response/Outcome: _____

8. Medical Necessity Justification
_____
_____

9. Additional Information / Pertinent Notes

Referring Physician Signature: _____ Date: _____ Stamp: _____

MD's: If clinical notes are supplied, please ONLY sign and stamp page 2