PINNACLE OPEN MRI

REQUEST FORM

By state law, the information disclosed to Pinnacle Open MRI is confidential. Pinnacle Open MRI will destroy any attached copies after stated purpose has been fulfilled

PART 1 PATIENT AND PHYSICIAN INFORMATION

PATIENT NAME:

____

LAST FIRST MI

SOCIAL SECURITY NUMBER: ______________

ADDRESS:

____

____

PHONE: ______________________________

DATE OF BIRTH (YYYY / MM / DD) SEX: M / F

____

MEDICAL PLAN & NUMBER:

____

REFERRING PROVIDER:

I CERTIFY THAT THIS PROCEDURE IS MEDICALLY NECESSARY FOR THE CARE OF MY PATIENT

____

SIGNATURE DATE

ADDRESS:

____

____

PHONE: ______________________________

FAX: ______________________________

ADDITIONAL COPIES TO:

____

REPORTS REQUIRED:

( ) STAT ( ) STANDARD WITHIN 24 HOURS

PART 2 MEDICAL HISTORY QUESTIONNAIRE

PROVISIONAL DIAGNOSIS

REASON FOR REFERRAL & CLINICAL HISTORY, INCLUDING DIAGNOSIS CODE (IC-10)
LIST AND/OR ATTACHED RELEVANT REPORTS:

____

____

____

____

PART 3 PATIENT APPOINTMENT INFORMATION

MRI EXAM REQUESTED (WITH IC-10 CODE / DIAGNOSIS CODE INCLUDED) ICD10: ______________

CPT: ______________

THE FOLLOWING PRECLUDES PERFORMING AND MRI EXAM:

☐ PACEMAKERS ☐ CERTAIN HEART VALVES ☐ CEREBRAL ANEURYSM CLIPS ☐ COCHLEAR IMPLANTS ☐ METAL FRAGMENTS IN EYES

INSURANCE AUTHORIZATION #:

NOTE: MAXIMUM WEIGHT ACCEPTED 500LBS

ALL SCANS INTERPRETED BY
ST. LAWRENCE RADIOLOGY
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