

Shingle Creek Medical Group

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Date: _____

scheduling@icaremri.com
 www.icaremri.com

Patient Name: _____ Phone: _____ DOB: _____ Male Female

Referring Physician: _____ Phone #: _____ Fax: _____ Email: _____

Working Diagnosis: ICD _____

Attorney : _____ Phone: _____

Insurance Company: _____ Claim Number/ID: _____

Adjuster: _____ Phone: _____

Send CD with Patient Set up Online Viewing FAX Report – Fax #: _____

Alerts: Pacemaker Implated Device(s) Metal Braces Metal in Body (where): _____

Reason For Exam: Confirm Rule Out Evaluate

Disc Injury Stenosis Tumor/Growth Degeneration Muscle/Tendon Injury Other _____

MRI		
<input type="checkbox"/> Brain	<input type="checkbox"/> Chest	<input type="checkbox"/> Hip L - R
<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Shoulder L - R	<input type="checkbox"/> Knee L - R
<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/> Elbow L - R	<input type="checkbox"/> Ankle L - R
<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> Wrist L - R	<input type="checkbox"/> Foot L - R
<input type="checkbox"/> Pelvis	<input type="checkbox"/> Hand L - R	<input type="checkbox"/> Other _____

X-Rays Upright & Weight Bearing			
Cervical Spine <input type="checkbox"/> Davis Trauma Series (7 views) <input type="checkbox"/> APOM <input type="checkbox"/> APLC <input type="checkbox"/> LCN <input type="checkbox"/> LCF/LCE <input type="checkbox"/> Obliques	Thoracic Spine <input type="checkbox"/> APT <input type="checkbox"/> LT <input type="checkbox"/> PA-Chest <input type="checkbox"/> LAT-Chest <input type="checkbox"/> Ribs: _____	Lumbar Spine <input type="checkbox"/> APLP <input type="checkbox"/> LLS <input type="checkbox"/> Lumbosacral Spot <input type="checkbox"/> Obliques <input type="checkbox"/> Other: _____	Upper/Lower Extremities <input type="checkbox"/> Shoulder L - R <input type="checkbox"/> Hip L - R <input type="checkbox"/> Elbow L - R <input type="checkbox"/> Knee L - R <input type="checkbox"/> Wrist L - R <input type="checkbox"/> Ankle L - R <input type="checkbox"/> Hand L - R <input type="checkbox"/> Foot L - R <input type="checkbox"/> Other _____

Significant History, Symptoms and Clinical Findings: _____

Type of Trauma: Auto Injury Work Injury Slip & Fall Other _____
 Neck Pain Thoracic Pain Decreased ROM Sciatica/Leg Tingling/Numbness/Pain
 Lumbar Pain Headache/Dizziness Arm Tingling/Numbness/Pain Muscle Spasm

Date of Trauma: _____ History of surgery/malignancy: YES NO

Physician Signature: _____