AMERICAN HEALTH Imaging

712 N. Washington Ave. Suite 102
Dallas, TX 75246

Scheduling: 214-515-0016
Fax: 214-515-0026

AmericanHealthImaging.com

APPOINTMENT DATE
_____/_____/_____
_____AM/PM

Please fax a copy of the patient's insurance information and any applicable clinical notes.

Patient Name: _____ DOB: _____ Height: _____ Weight: _____

Phone/Home#: _____ Work/Other#: _____ Ins. Provider: _____

Ins. Group#: _____ Ins. Member#: _____ Precert/Auth#: _____

HEAD & NECK MRI	CONTRAST WITH	CONTRAST W/OUT
☐ Brain	_____	_____
☐ IAC's	_____	_____
☐ Pituitary-Sella	_____	_____
☐ Orbits	_____	_____
☐ TMJ	_____	_____
☐ Soft Tissue Neck	_____	_____
MRA		
☐ Circle of Willis (Head)	_____	_____
☐ Carotids / Vertebrals	_____	_____
☐ Renal	_____	_____

ORTHO MRI		CONTRAST WITH	CONTRAST W/OUT
☐ Hand	L R	_____	_____
☐ Wrist	L R	_____	_____
☐ Elbow	L R	_____	_____
☐ Shoulder	L R	_____	_____
☐ Foot	L R	_____	_____
☐ Ankle	L R	_____	_____
☐ Knee	L R	_____	_____
☐ Hip	L R	_____	_____
OTHER MRI			
☐_____		_____	_____

BODY MRI	CONTRAST WITH	CONTRAST W/OUT
☐ Chest	_____	_____
☐ Abdomen	_____	_____
☐ Fat Quantification		
☐ Brachial Plexus	_____	_____
☐ Pelvis	_____	_____
SPINE MRI		
☐ Cervical	_____	_____
☐ Thoracic/Dorsal	_____	_____
☐ Lumbar	_____	_____
BREAST MRI		
☐ Implant	_____	_____
☐ Mass	_____	_____

CT SCANS	CONTRAST WITH	CONTRAST W/OUT
☐ Brain	_____	_____
☐ Sinuses	_____	_____
☐ Sinus Stealth	_____	_____
☐ IAC's	_____	_____
☐ Pituitary	_____	_____
☐ Orbits	_____	_____
☐ Abdomen	_____	_____
☐ Pelvis	_____	_____
☐ Abdomen/Pelvis - Kidney Stone	_____	_____

CT SCANS	CONTRAST WITH	CONTRAST W/OUT
☐ CTA Pulmonary	_____	_____
☐ CTA Chest - Abdomen/Pelvis (AAA)	_____	_____
☐ CTA Chest - Aneurysm	_____	_____
☐ Cervical Spine	_____	_____
☐ Thoracic Spine	_____	_____
☐ Lumbar Spine	_____	_____
☐ Chest	_____	_____
☐ Soft Tissue Neck	_____	_____
☐ Extremities _____ L R	_____	_____
☐ Other _____		

X-RAY

☐ Orthopedic _____ Right Left Bilateral
☐ Chest
☐ Abdomen
☐ Spine _____ Flex/Ext
☐ Other _____

Referring Physician Name: _____

Physician Signature: _____

Phone: _____ Fax: _____

☐ Report Only ☐ CD ☐ Films ☐ Images w/ PT ☐ STAT

ICD-10 Code / Diagnosis: _____

Attorney Name: _____ Attorney Number: _____

☐ Work Comp ☐ MVA ☐ Slip & Fall