



TWO CONVENIENT LOCATIONS TO SERVE YOUR PATIENTS

8627 Cinnamon Creek Drive
 Building 2
 San Antonio, TX 78240
 Phone: 210-641-0111
 Fax: 210-641-0555

10131 Military Drive West
 Suite 101
 San Antonio, TX 78251
 Phone: 210-305-8300
 Fax: 210-305-8301

APPOINTMENT DATE _____/_____/_____ _____ AM / PM
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Please fax a copy of the patient's insurance information and any applicable clinical notes.

Patient Name: _____ DOB: _____ Height: _____ Weight: _____
 Phone/Home#: _____ Work/Other#: _____ Insurance Provider: _____
 Ins. Group#: _____ Ins. Member#: _____ Precert/Auth#: _____
 Referring Physician: _____ Contact Person: _____
 Physician Phone#: _____ Physician Fax#: _____

HEAD & NECK MRI			ORTHO MRI			BODY MRI		
	WITH CONTRAST	WITHOUT CONTRAST		WITH CONTRAST	WITHOUT CONTRAST		WITH CONTRAST	WITHOUT CONTRAST
<input type="checkbox"/> Brain	_____	_____	<input type="checkbox"/> Finger/Thumb L R	_____	_____	<input type="checkbox"/> Sacrum/Coccyx	_____	_____
<input type="checkbox"/> Volumetric Study	_____	_____	<input type="checkbox"/> Hand L R	_____	_____	<input type="checkbox"/> MRCP	_____	_____
<input type="checkbox"/> DTI	_____	_____	<input type="checkbox"/> Wrist L R	_____	_____	<input type="checkbox"/> Chest	_____	_____
<input type="checkbox"/> IAC'S	_____	_____	<input type="checkbox"/> Elbow L R	_____	_____	<input type="checkbox"/> Abdomen	_____	_____
<input type="checkbox"/> Pituitary-Sella	_____	_____	<input type="checkbox"/> Shoulder L R	_____	_____	<input type="checkbox"/> Enterography	_____	_____
<input type="checkbox"/> Orbits	_____	_____	<input type="checkbox"/> Scapula L R	_____	_____	<input type="checkbox"/> Brachial Plexus	_____	_____
<input type="checkbox"/> TMJ	_____	_____	<input type="checkbox"/> Foot L R	_____	_____	<input type="checkbox"/> Pelvis (bony)	_____	_____
<input type="checkbox"/> Soft Tissue Neck	_____	_____	<input type="checkbox"/> Ankle L R	_____	_____	<input type="checkbox"/> Pelvis (soft tissue)	_____	_____
<input type="checkbox"/> Cranial Nerves	_____	_____	<input type="checkbox"/> Knee L R	_____	_____	SPINE MRI		
MRA			<input type="checkbox"/> Hip (thigh) L R	_____	_____	<input type="checkbox"/> Cervical	_____	_____
<input type="checkbox"/> Circle of Willis (Head)	_____	_____	<input type="checkbox"/> Lower Leg L R	_____	_____	<input type="checkbox"/> Thoracic/Dorsal	_____	_____
<input type="checkbox"/> Carotids/Vertebrals	_____	_____	OTHER MRI			<input type="checkbox"/> Lumbar	_____	_____
<input type="checkbox"/> Renal	_____	_____	<input type="checkbox"/> _____	_____	_____			

CT SCANS								
	WITH CONTRAST	WITHOUT CONTRAST		WITH CONTRAST	WITHOUT CONTRAST		WITH CONTRAST	WITHOUT CONTRAST
<input type="checkbox"/> Brain	_____	_____	<input type="checkbox"/> Pelvis	_____	_____	<input type="checkbox"/> CTA Head	_____	_____
<input type="checkbox"/> Facial Bones	_____	_____	<input type="checkbox"/> Abdomen/Pelvis	_____	_____	<input type="checkbox"/> CTA Neck	_____	_____
<input type="checkbox"/> Sinuses	_____	_____	<input type="checkbox"/> Abdomen/Pelvis - Kidney Stone	_____	_____	<input type="checkbox"/> Cervical Spine	_____	_____
<input type="checkbox"/> Sinus Stealth	_____	_____	<input type="checkbox"/> Brachial Plexus	_____	_____	<input type="checkbox"/> Thoracic Spine	_____	_____
<input type="checkbox"/> IAC's	_____	_____	<input type="checkbox"/> Enterography	_____	_____	<input type="checkbox"/> Lumbar Spine	_____	_____
<input type="checkbox"/> Pituitary	_____	_____	<input type="checkbox"/> CTA Pulmonary	_____	_____	<input type="checkbox"/> Chest	_____	_____
<input type="checkbox"/> Orbits	_____	_____	<input type="checkbox"/> CTA - Abdomen/Pelvis (AAA)	_____	_____	<input type="checkbox"/> Soft Tissue Neck	_____	_____
<input type="checkbox"/> Abdomen	_____	_____	<input type="checkbox"/> CTA Chest - Aneurysm	_____	_____	<input type="checkbox"/> Extremities ____ L R	_____	_____
						<input type="checkbox"/> Other _____		

ATTORNEYS

ICD-10 Code / Diagnosis: _____

Attorney Name: _____ Attorney Number: _____ Date of Injury: _____

Work Comp MVA Slip & Fall

Report Only CD Films Images w/PT STAT

ICD-10 Code / Diagnosis: _____

Special Instructions: _____

Physician Signature: _____ Date: _____

FREE TRANSPORTATION • FREE PARKING • SAME DAY APPOINTMENTS • NEXT DAY RESULTS