



- Mt. Pleasant (MRI, CT, DTI)
- Summerville (MRI, CT)

APPOINTMENT DATE

____/____/____

_____ AM / PM

AMERICAN HEALTH IMAGING

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	CT SCANS	
<input type="checkbox"/> WITHOUT CONTRAST <input type="checkbox"/> WITH CONTRAST <input type="checkbox"/> WITH & WITHOUT CONTRAST			<input type="checkbox"/> WITHOUT CONTRAST <input type="checkbox"/> IV ONLY (NO ORAL) <input type="checkbox"/> ORAL AND IV	
<input type="checkbox"/> Brain <input type="checkbox"/> Volumetric Study <input type="checkbox"/> DTI <input type="checkbox"/> IAC'S <input type="checkbox"/> Pituitary-Sella <input type="checkbox"/> Orbits <input type="checkbox"/> TMJ <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Cranial Nerves <div style="background-color: #e0e0e0; padding: 2px;">MRA</div> <input type="checkbox"/> Circle of Willis (Head) <input type="checkbox"/> Carotids/Vertebrales <input type="checkbox"/> Renal	<input type="checkbox"/> Finger/Thumb L R <input type="checkbox"/> Hand L R <input type="checkbox"/> Wrist L R <input type="checkbox"/> Elbow L R <input type="checkbox"/> Shoulder L R <input type="checkbox"/> Scapula L R <input type="checkbox"/> Toe L R <input type="checkbox"/> Foot L R <input type="checkbox"/> Ankle L R <input type="checkbox"/> Knee L R <input type="checkbox"/> Hip L R <input type="checkbox"/> Thigh L R <input type="checkbox"/> Lower Leg L R	<input type="checkbox"/> Sacrum/Coccyx <input type="checkbox"/> MRCP <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Enterography <input type="checkbox"/> Brachial Plexus <input type="checkbox"/> Pelvis (bony) <input type="checkbox"/> Pelvis (soft tissue) <input type="checkbox"/> Liver <div style="background-color: #e0e0e0; padding: 2px;">SPINE MRI</div> <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic/Dorsal <input type="checkbox"/> Lumbar <input type="checkbox"/> Other _____	<input type="checkbox"/> Brain <input type="checkbox"/> Facial Bones <input type="checkbox"/> Sinuses <input type="checkbox"/> Sinus Stealth <input type="checkbox"/> IAC's <input type="checkbox"/> Pituitary <input type="checkbox"/> Orbits <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Abdomen/Pelvis Enterography <input type="checkbox"/> Abdomen/Pelvis Kidney Stone <input type="checkbox"/> Urogram <input type="checkbox"/> Enterography w/IV	<input type="checkbox"/> Extremities L R Specify _____ <input type="checkbox"/> CTA Pulmonary <input type="checkbox"/> CTA - Abdomen/Pelvis (AAA) <input type="checkbox"/> CTA Chest - Aneurysm <input type="checkbox"/> CTA Head <input type="checkbox"/> CTA Neck <input type="checkbox"/> CTA Runoff <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Chest <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Renal (wo/w IV) <input type="checkbox"/> Liver (wo/w IV) <input type="checkbox"/> Other _____

ATTORNEYS

Attorney Name: _____	Attorney Number: _____	Date of Injury: _____
<input type="checkbox"/> Work Comp <input type="checkbox"/> MVA <input type="checkbox"/> Slip & Fall		

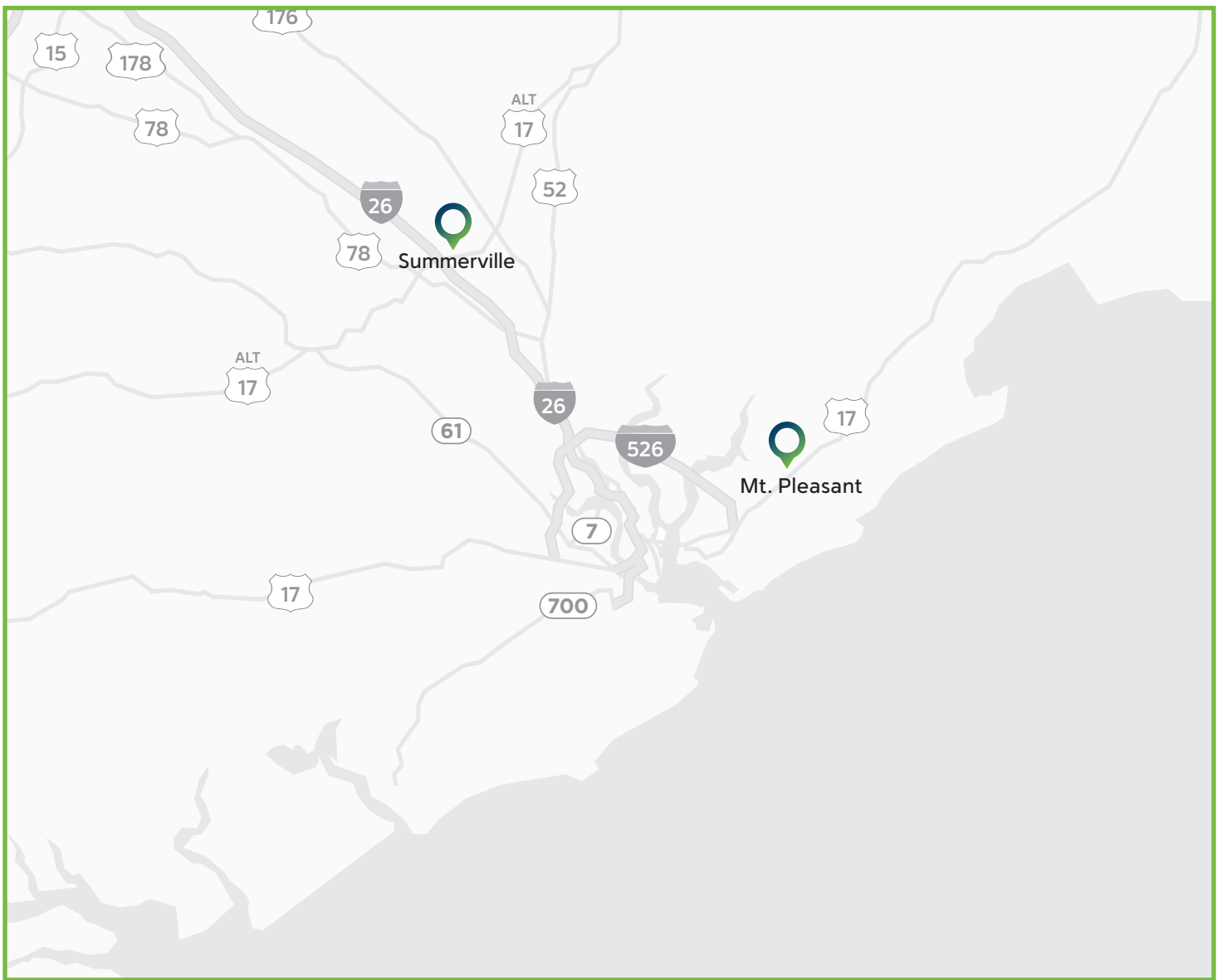
Report Only
 CD
 Images w/PT
 STAT

ICD-10 Code / Diagnosis: _____

Special Instructions: _____

Physician Signature: _____ Date: _____

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



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