



- Brunswick MRI, CT, DTI
- Savannah MRI, CT, DTI

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: _____
 Patient Phone #: _____ Circle: Cell or Home Call Patient to Schedule Appointment
 Insurance Name/Group#/Member #: _____
 Precert/Auth #: _____ ICD-10 Code/Diagnosis: _____

Report Only CD STAT STAT CALL REPORT TO: _____
 Draw Labs Creatinine: _____ GFR: _____ Date Drawn: _____

Head/Neck MRI		Ortho MRI		Body MRI	
<input type="checkbox"/> WITHOUT CONTRAST	<input type="checkbox"/> WITH CONTRAST	<input type="checkbox"/> WITHOUT & WITH CONTRAST			
<input type="checkbox"/> Brain	<input type="checkbox"/> Finger/Thumb	L	R	<input type="checkbox"/> Sacrum/Coccyx	
<input type="checkbox"/> NeuroQuant	<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"/> IACs	<input type="checkbox"/> Elbow	L	R	<input type="checkbox"/> Abdomen	
<input type="checkbox"/> Pituitary	<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 (Boney)	
<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/> Ankle	L	R	<input type="checkbox"/> Pelvis (Soft Tissue)	
<input type="checkbox"/> Crainial Nerves	<input type="checkbox"/> Knee	L	R	SPINE MRI	
OTHER MRI	<input type="checkbox"/> Hip (Thigh)	L	R	<input type="checkbox"/> Cervical	
<input type="checkbox"/> _____	<input type="checkbox"/> Lower Leg	L	R	<input type="checkbox"/> Thoracic/Dorsal	
				<input type="checkbox"/> Lumbar	

ANGIOGRAPHY		
<input type="checkbox"/> WITHOUT CONTRAST	<input type="checkbox"/> WITH CONTRAST	
<input type="checkbox"/> WITHOUT & WITH CONTRAST		
MRI Angiography		
<input type="checkbox"/> MRA Head	<input type="checkbox"/> MRA Neck	<input type="checkbox"/> MRA Renal
CT Angiography		
<input type="checkbox"/> CTA Brain	<input type="checkbox"/> CTA Chest/Abdomen	
<input type="checkbox"/> CTA Caratoids	<input type="checkbox"/> CTA Renal	
<input type="checkbox"/> CTA Head/Neck	<input type="checkbox"/> CTA Abdomen/Pelvis	
<input type="checkbox"/> CTA Upper Extremities	<input type="checkbox"/> CTA Abdomen/Pelvis and Bilateral Runoff	
<input type="checkbox"/> L <input type="checkbox"/> R		
<input type="checkbox"/> CTA Chest	<input type="checkbox"/> CTA Pelvis	
<input type="checkbox"/> PE Protocol	<input type="checkbox"/> CTA Lower Extremities	
<input type="checkbox"/> Aorta Protocol	<input type="checkbox"/> L <input type="checkbox"/> R	
<input type="checkbox"/> Subclavian Protocol		

CT		
<input type="checkbox"/> WITHOUT CONTRAST	<input type="checkbox"/> IV ONLY (no oral)	<input type="checkbox"/> ORAL & IV
<input type="checkbox"/> WITHOUT & WITH CONTRAST		
<input type="checkbox"/> Brain	<input type="checkbox"/> Abdomen	EXTREMITIES
<input type="checkbox"/> Facial Bones	<input type="checkbox"/> Pelvis	<input type="checkbox"/> Shoulder L R
<input type="checkbox"/> Sinuses	<input type="checkbox"/> Abdomen/Pelvis	<input type="checkbox"/> Elbow L R
<input type="checkbox"/> Sinus Stealth	<input type="checkbox"/> Abdomen/Pelvis (Kidney Stone)	<input type="checkbox"/> Wrist L R
<input type="checkbox"/> IACs	<input type="checkbox"/> Urogram	<input type="checkbox"/> Hand L R
<input type="checkbox"/> Pituitary	<input type="checkbox"/> Enterography	<input type="checkbox"/> Hip L R
<input type="checkbox"/> Orbits	<input type="checkbox"/> Renal	<input type="checkbox"/> Knee L R
<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/> Liver	<input type="checkbox"/> Ankle L R
<input type="checkbox"/> Chest	<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Foot L R
<input type="checkbox"/> Calcium Scoring	<input type="checkbox"/> Thoracic Spine	OTHER CT
<input type="checkbox"/> LDCT Lung Cancer Screening	<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> _____

ARTHROGRAMS (Savannah Only)				
<input type="checkbox"/> MRI		<input type="checkbox"/> CT		
<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	

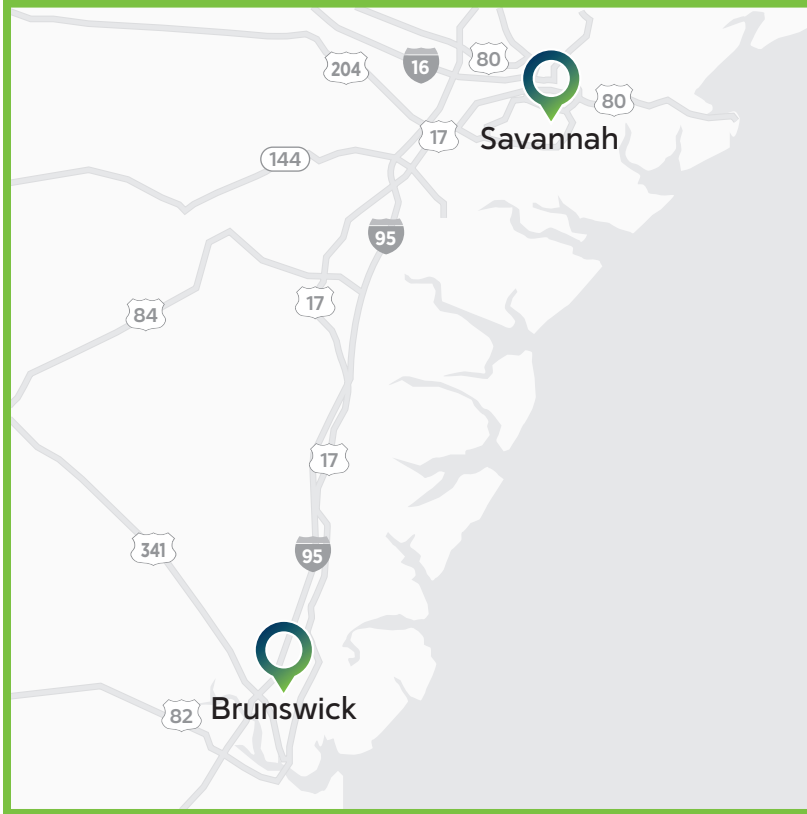
ATTORNEY
ICD-10 Code / Diagnosis: _____

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

SPECIAL INSTRUCTIONS

Physician Signature: _____
 Physician Name: _____ Date: _____
 Contact Person: _____ Physician Phone #: _____ Physician Fax #: _____

2 CONVENIENT LOCATIONS IN COASTAL GEORGIA



SAVANNAH

30 Janet Drive, #101

Savannah, GA 31405

Phone: 912.355.6736

Fax: 912.244.2900

SERVICES: MRI • CT • DTI

BRUNSWICK

1103 Fountain Lake Drive

Brunswick, GA 31525

Phone: 912.267.6736

Fax: 912.262.1922

SERVICES: MRI • CT • DTI

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