



- Brookwood 3T** MRI, CT, Angiogram
- Downtown** MRI, Angiogram, Arthrogram, Fluoroscopy
- Grandview** MRI, CT, Angiogram, Arthrogram, DTI, Fluoroscopy
- Greystone** MRI, CT, US, X-ray, Angiogram, Arthrogram, DTI, Fluoroscopy, Myelogram
- Homewood** MRI, CT, X-ray, Angiogram, Arthrogram, Fluoroscopy, Myelogram
- Huntsville** MRI, CT, Angiogram, DTI
- Madison** MRI, CT, Angiogram, DTI
- Open Upright MRI** MRI (Advanced Open), Angiogram
- Shelby** MRI, CT, US, Angiogram, Arthrogram, Fluoroscopy

APPOINTMENT DATE

____/____/____
 _____ AM / PM

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: _____

Head/Neck MRI	Ortho MRI	Body MRI
<input type="checkbox"/> WITHOUT CONTRAST <input type="checkbox"/> Brain <input type="checkbox"/> Brain for ARIA <input type="checkbox"/> Cranial Nerves <input type="checkbox"/> DTI <input type="checkbox"/> IACs <input type="checkbox"/> Pituitary-Sella <input type="checkbox"/> Volumetric Study specify: _____ <input type="checkbox"/> Orbits <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> TMJ MRA <input type="checkbox"/> Circle of Willis (Head) <input type="checkbox"/> Carotids/Vertebrals <input type="checkbox"/> Renal	<input type="checkbox"/> WITH CONTRAST <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"/> 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 OTHER MRI <input type="checkbox"/> _____	<input type="checkbox"/> WITHOUT & WITH CONTRAST <input type="checkbox"/> Brachial Plexus <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> MRCP <input type="checkbox"/> Pelvis (Bony) <input type="checkbox"/> Pelvis (Soft Tissue) <input type="checkbox"/> Sacrum/Coccyx SPINE MRI <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic/Dorsal <input type="checkbox"/> Lumbar

CT		
<input type="checkbox"/> WITHOUT CONTRAST	<input type="checkbox"/> WITH CONTRAST	<input type="checkbox"/> WITHOUT & WITH CONTRAST
<input type="checkbox"/> Brain <input type="checkbox"/> Facial Bones <input type="checkbox"/> Sinuses <input type="checkbox"/> Sinus Stealth <input type="checkbox"/> IACs <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"/> Extremities L R SPECIFY _____	<input type="checkbox"/> CTA Head <input type="checkbox"/> CTA Neck <input type="checkbox"/> CTA Pulmonary <input type="checkbox"/> CTA Chest - Aneurysm <input type="checkbox"/> CTA - Abdomen/Pelvis (AAA) <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Chest <input type="checkbox"/> Calcium Cardiac Scoring <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Other:	

ULTRASOUND (Greystone & Shelby Only)		
<input type="checkbox"/> Pelvis + <input type="checkbox"/> Abdomen/Complete * <input type="checkbox"/> Abdomen/Limited * <input type="checkbox"/> Endovaginal <input type="checkbox"/> Abdominal Aorta * <input type="checkbox"/> Gallbladder <input type="checkbox"/> Abdomen + Drink 32oz of fluids 1 hour prior to appointment *Nothing to eat or drink after midnight	<input type="checkbox"/> Liver/Pancreas <input type="checkbox"/> Chest Wall <input type="checkbox"/> Renals <input type="checkbox"/> Thyroid <input type="checkbox"/> Breast <input type="checkbox"/> Orbits	<input type="checkbox"/> Doppler: Carotid <input type="checkbox"/> Doppler: Venous <input type="checkbox"/> Doppler: Other _____ <input type="checkbox"/> Testicular OTHER <input type="checkbox"/> _____

ARTHROGRAM/MYELOGRAM		
ARTHROGRAM		<input type="checkbox"/> MRI <input type="checkbox"/> CT
<input type="checkbox"/> Shoulder L R <input type="checkbox"/> Elbow L R <input type="checkbox"/> Wrist L R <input type="checkbox"/> Hand L R	<input type="checkbox"/> Hip L R <input type="checkbox"/> Knee L R <input type="checkbox"/> Ankle L R <input type="checkbox"/> Foot L R	
MYELOGRAM		
<input type="checkbox"/> Cervical	<input type="checkbox"/> Thoracic	<input type="checkbox"/> Lumbar

X-RAY (Greystone & Homewood Only)		
<input type="checkbox"/> Orthopedic _____	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral	
<input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Spine _____	<input type="checkbox"/> Flex/Ext _____	
<input type="checkbox"/> Other _____		

ATTORNEY
ICD-10 Code / Diagnosis: _____
Attorney Name: _____ Date of Injury: _____
Attorney Number: _____ <input type="checkbox"/> Work Comp <input type="checkbox"/> MVA <input type="checkbox"/> Slip & Fall

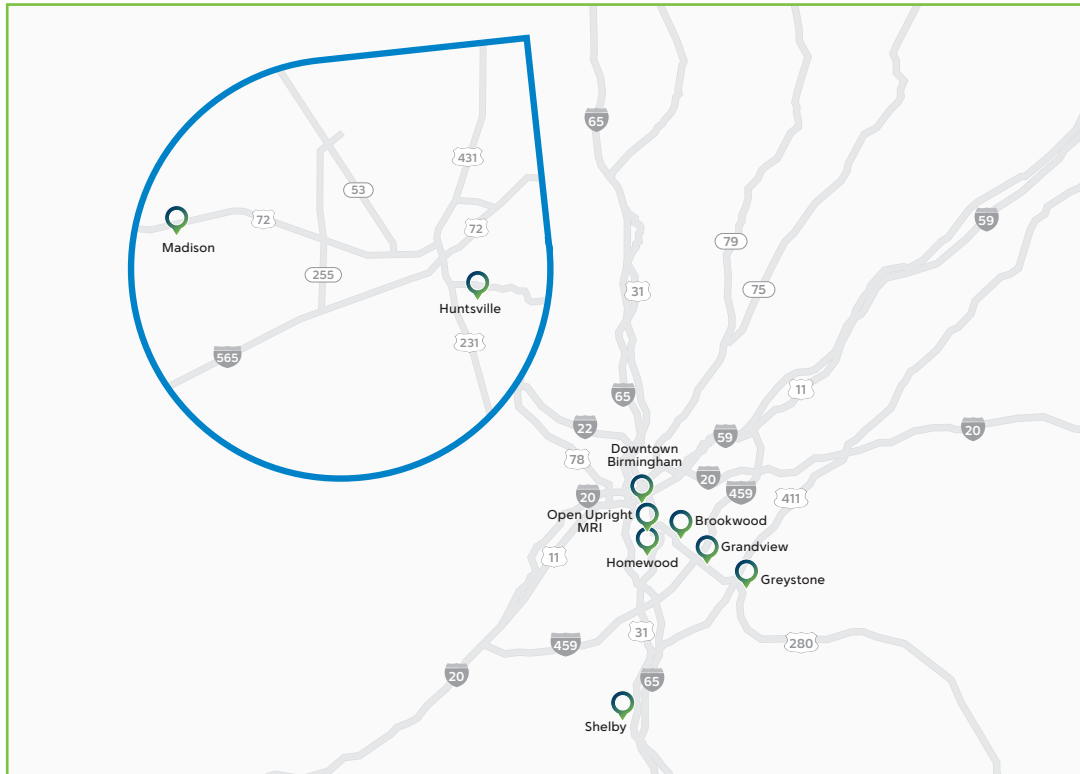
SPECIAL INSTRUCTIONS

The radiologist may modify the test design; including the number of views, thickness of tomographic sections, and use or non-use of contrast.

Physician Signature: _____ Date: _____

Physician Name: _____ Physician Phone #: _____ Physician Fax #: _____

9 CONVENIENT LOCATIONS IN ALABAMA



BIRMINGHAM DOWNTOWN

2101 4th Avenue South, Suite 100
Birmingham, AL 35233
Phone: 205.251.1300 **Fax:** 205.251.1313

HUNTSVILLE

2338 Whitesburg Drive, Suite F
Huntsville, AL 35801
Phone: 256.384.0313 **Fax:** 256.384.0316

BROOKWOOD 3T

509 Brookwood Boulevard, Suite 111
Birmingham, AL 35209
Phone: 205.414.9850 **Fax:** 205.414.9855

MADISON

8425 Wann Drive, Suite 100
Madison, AL 35758
Phone: 256.581.0106 **Fax:** 256.581.0107

GRANDVIEW

3570 Grandview Parkway, Suite 102
Birmingham, AL 35243
Phone: 205.977.2274 **Fax:** 205.977.2474

OPEN UPRIGHT MRI

3105 Independence Drive, Suite 101
Homewood, AL 35209
Phone: 205.871.3335 **Fax:** 205.871.3305

GREYSTONE

7500 Hugh Daniel Drive, Suite 150
Hoover, AL 35242
Phone: 205.995.4900 **Fax:** 205.995.0203

SHELBY

224 1st Street North, Suite 150
Alabaster, AL 35007
Phone: 205.663.4674 **Fax:** 205.663.4807

HOMEWOOD

1 Independence Plaza, #140
Homewood, AL 35209
Phone: 205.870.1979 **Fax:** 205.870.1929

www.americanhealthimaging.com