

# MRI REFERRAL FORM



7 Vanderbilt Park Drive  
Asheville, NC 28803  
Phone - (828) 274-7435

**FAX REQUEST TO - (828) 274-3593**

Patient Name \_\_\_\_\_  Male  Female

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Mailing Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone #'s (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_

Insurance Company \_\_\_\_\_ Carolina Access PCP # \_\_\_\_\_

**\*Attach copy of card (front & back)**

Clinical History: \_\_\_\_\_

Type of Scan: \_\_\_\_\_ Contrast: YES NO

Approximate Weight \_\_\_\_\_ lbs. **\* required**

*If possible, send or have sent any X-rays or Imaging studies related to the patient's current clinical problem.*

PATIENT HISTORY	No	Yes
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Intracranial Vascular Clips	<input type="checkbox"/>	<input type="checkbox"/>
Ear Implants	<input type="checkbox"/>	<input type="checkbox"/>
Metal Working - either hobby or work (grinding, sharpening metals)	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic (insulin pump)	<input type="checkbox"/>	<input type="checkbox"/>
Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/> If yes, ordering physician will need to prescribe pre-medications.
Recent X-rays related to current problem	<input type="checkbox"/>	<input type="checkbox"/> If yes, have patient bring to exam.
Previous surgery related to current problem	<input type="checkbox"/>	<input type="checkbox"/>
Any scheduling conflict dates	<input type="checkbox"/>	<input type="checkbox"/> If yes, please list:

**NAME OF ORDERING PHYSICIAN:** \_\_\_\_\_  
*please print*

**SIGNATURE OF ORDERING PHYSICIAN:** \_\_\_\_\_  
**\* required**

Address Of Ordering Physician: \_\_\_\_\_  
*street name*

\_\_\_\_\_ *city* \_\_\_\_\_ *state* \_\_\_\_\_ *zip code*