



REFERRAL FORM

PATIENT NAME: _____ TODAY'S DATE: _____

PHONE(S): _____ D.O.B. _____

EMAIL: _____

ADDRESS: _____

EXAM REQUESTED: _____

REASON FOR EXAM: _____ DX CODE: _____

APPT. DATE/TIME: _____ ****Bring I.D. to Appt. / Traiga su Identificación****

P.I. ATTORNEY: _____

ATTY. CONTACT: _____ PHONE: _____ D.O.I. _____

- Medicare PPO P.I. (Lien) Cash Other

EXAM INFORMATION

PROCEDURE

- MRI
- CAT / CT Scan
- X-Ray
- Ultrasound
- Bone Density
- PET or PET/CT
- MR Arthrogram
- MR Angiography

BODY PART

- Head/Brain
- Sinuses
- Neck—Soft Tissue
- Cervical Spine
- Thoracic Spine
- Lumbar Spine
- Chest
- Abdomen
- Pelvis
- Other: _____
- Hip (L, R, Both)
- Knee (L, R, Both)
- Ankle (L, R, Both)
- Foot (L, R, Both)
- Shoulder (L, R, Both)
- Elbow (L, R, Both)
- Wrist (L, R, Both)
- Hand (L, R, Both)
- TMJ (L, R, Both)

OPTIONS

- Without Contrast
 - With Contrast
 - IV Oral Rectal
 - With / Without Contrast
 - IV Oral Rectal
 - Comparison Study
-
- Open MRI Required
 - Patient Claustrophobic
 - Patient Over 300 Lbs.

PHYSICIAN INFORMATION

REFERRING PHY: _____ SIGNATURE: _____

PHONE: _____ FAX: _____

PLEASE FAX PATIENT INSURANCE or PI INFORMATION WITH REFERRAL

We accept Liens on Personal Injury
Our facilities are equipped with **HIGH FIELD MRI's, STAND UP & OPEN MRI's** (for claustrophobic patients)
AFTER HOURS & WEEKEND APPOINTMENTS AVAILABLE.
Children **MUST** be accompanied by adult. Se Habla Español

Toll Free: (800) 558-2223

Fax: (888) 715-7001

Need more referral pads?

To request more pads please visit the following website

www.precisemri.com/request

Precise Imaging Corporate Office
6710 Kester Ave. Van Nuys, CA 91405

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Fresno
Gardena
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Lafayette
Laguna Hills
Lodi
Los Angeles

Los Gatos
Lynwood
Marina Del Rey
Montclair
Newport Beach
North Hollywood
Northridge
Ontario
Oxnard
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Email Our Scheduling Department

scheduling@precisemri.com
