



MRI ORDERS

Fax to: 608-663-4869

Phone: 608-663-6674

Toll free: 877-410-6674

2101 Zeier Road
Madison, WI 53704

Patient Information

Patient Name _____ Social Security # _____
Date of Birth _____ Sex _____ Phone (H) _____ (W) _____
Address _____

MRI Order

Anatomical Site(s) to be Scanned _____ Contrast - Yes or No (Circle)

Reason For MRI Exam (Symptoms/Diagnosis) _____
_____ ICD-9 Code _____

___ Yes ___ No Pacemaker (If Yes, MRI Exam Cannot be Performed)

___ Yes ___ No Metal in Eye or Past/Present Employment in Metalworking (If Yes, Submit Orbit X-Rays report for Review)

Ordering Physician _____ Person Scheduling Exam _____

UPIN _____ Phone _____ Fax _____

Address _____

Physician Signature _____ Date _____

Insurance Information

Primary Insurer _____

Subscriber ID# _____

Phone _____

Secondary Insurer _____

Subscriber ID # _____

Phone _____

OFFICE USE ONLY

Person Contacted _____

Date of Contact _____

Authorization # _____

Person Contacted _____

Date of Contact _____

Authorization # _____

FILMS (Please Check One)

- ___ Give to patient for follow-up appt.
- ___ Mail the day after the MRI exam
- ___ None needed now