



Patient's name: _____ DOB: _____

Mobile #: _____ Alternate #: _____ Insurance: _____

Appointment date: _____ Appointment time: _____ Authorization/AUC: _____

Insurance (Please fax front and back of patient's card and any clinical information to 828.250.0142)

Clinical indications/Signs/Symptoms: _____

ICD-10 Code(s): _____

MRI	CT	REPORT DELIVERY
<p>CONTRAST</p> <p><input type="radio"/> Radiologist Discretion</p> <p><input type="radio"/> W/O <input type="radio"/> W/ & W/O</p>	<p>CONTRAST</p> <p><input type="radio"/> Radiologist Discretion</p> <p><input type="radio"/> W/ <input type="radio"/> W/O</p>	<p><input type="radio"/> STAT Fax Fax#: _____</p> <p><input type="radio"/> Call Report Cell or backline #: _____</p> <p>Standard Report in 24-48 hours.</p>
<p><input type="radio"/> Brain</p> <p><input type="radio"/> MRA Brain</p> <p><input type="radio"/> Brain (Pituitary)</p> <p><input type="radio"/> Brain (IAC)</p> <p><input type="radio"/> Brain (Orbits)</p> <p><input type="radio"/> MRA Carotids</p> <p><input type="radio"/> MRA: _____</p> <p><input type="radio"/> Cervical Spine</p> <p><input type="radio"/> Thoracic Spine</p> <p><input type="radio"/> Lumbar Spine</p> <p><input type="radio"/> Soft Tissue Neck</p> <p><input type="radio"/> Chest</p> <p><input type="radio"/> Abdomen</p> <p><input type="radio"/> MRCP</p> <p><input type="radio"/> Pelvis</p> <p><input type="radio"/> Shoulder R L</p> <p><input type="radio"/> Elbow R L</p> <p><input type="radio"/> Wrist R L</p> <p><input type="radio"/> Hand R L</p> <p><input type="radio"/> Hip R L</p> <p><input type="radio"/> Knee R L</p> <p><input type="radio"/> Ankle R L</p> <p><input type="radio"/> Foot R L</p> <p><input type="radio"/> Prostate</p> <p><input type="radio"/> Other: _____</p> <p>_____</p>	<p><input type="radio"/> Head</p> <p><input type="radio"/> Orbits</p> <p><input type="radio"/> Limited Sinus</p> <p><input type="radio"/> Paranasal Sinus Stereotactic Protocol: _____</p> <p><input type="radio"/> Facial Bones</p> <p><input type="radio"/> Abdomen & Pelvis</p> <p><input type="radio"/> Abdomen</p> <p><input type="radio"/> Pelvis</p> <p><input type="radio"/> Chest</p> <p><input type="radio"/> Lumbar Spine</p> <p><input type="radio"/> Cervical Spine</p> <p><input type="radio"/> Thoracic Spine</p> <p><input type="radio"/> Soft Tissue Neck</p> <p><input type="radio"/> CT Angiography of: _____</p> <p>_____</p> <p><input type="radio"/> Extremity: _____</p> <p><input type="radio"/> Other: _____</p> <p>_____</p> <p>Advanced Imaging</p> <p><input type="radio"/> 3D Reconstruction</p>	<p>X-RAY</p> <p><input type="radio"/> Chest</p> <p><input type="radio"/> KUB</p> <p><input type="radio"/> Abd-Supine & Upright</p> <p><input type="radio"/> Abd Series (incl. PA CXR)</p> <p><input type="radio"/> Cervical Views: _____</p> <p><input type="radio"/> Thoracic Views: _____</p> <p><input type="radio"/> Lumbar Views: _____</p> <p><input type="radio"/> Pelvis</p> <p><input type="radio"/> Ribs Rt Lt</p> <p><input type="radio"/> Hip Rt Lt</p> <p><input type="radio"/> Shoulder Rt Lt</p> <p><input type="radio"/> Wrist Rt Lt</p> <p><input type="radio"/> Hand Rt Lt</p> <p><input type="radio"/> Knee Rt Lt</p> <p><input type="radio"/> Ankle Rt Lt</p> <p><input type="radio"/> Foot Rt Lt</p> <p><input type="radio"/> Other: _____</p>
	<p>IMPLANT</p> <p>Brand: _____</p> <p>Model #: _____</p> <p><input type="radio"/> Pacemaker (no MRI)</p> <p><input type="radio"/> Neurostimulator</p> <p><input type="radio"/> Other: _____</p>	<p>COMPARISON STUDIES</p> <p>Date of service: _____</p> <p>Location: _____</p> <p>Type of study: _____</p>
		<p>ARTHROGRAM</p> <p><input type="radio"/> Arthrogram of: _____</p> <p>_____</p> <p>Followed by MRI, CT, or X-ray (Circle one)</p>

Provider name (printed): _____ Provider signature: _____

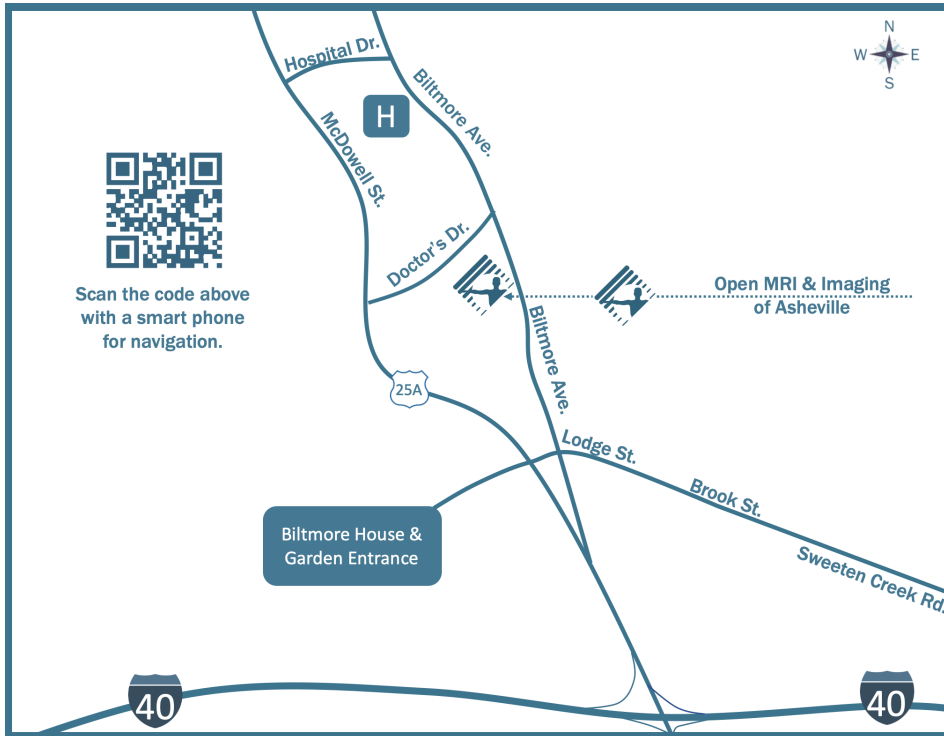
Office phone: _____ Fax: _____ Date: _____

PATIENT INSTRUCTIONS

BRING THIS ORDER WITH YOU TO YOUR SCHEDULED EXAM

VISIT US ONLINE AT WWW.ASHEVILLEOPENMRI.COM FOR DRIVING DIRECTIONS AND TO LEARN MORE ABOUT OUR IMAGING FACILITY AND SERVICES.

Our Location



Open MRI & Imaging of Asheville

675 Biltmore Avenue, Ste. A

Asheville, NC 28803

Phone: 828.250.0181

Fax: 828.250.0142

MRI (Magnetic Resonance Imaging)

Our office will contact you 24 hours before your appointment to confirm your appointment and provide prep instructions.

Do not wear eye makeup or mascara for ANY Brain & Neck studies. Do not wear any jewelry or hairpins. Wear comfortable clothing.

Let us know if you have:

- Metallic fragments in your eyes or previous injury to the eye involving a metal object
- Any type of implanted mechanical pump
- Any type of surgery within the past 8 weeks
- A history of cancer
- A pacemaker
- An aneurysm clip
- Any metallic implant
- Any type of implanted stimulator

Let us know if you are:

- Allergic to CT or MRI contrast
- Claustrophobic
- Pregnant/Nursing
- In need of special assistance

CT (Computed Tomography)

Our office will contact you 24 hours before your appointment to confirm your appointment and provide prep instructions.



Open MRI & Imaging of Asheville

www.AshevilleOpenMRI.com