BERMUDA HEALTHCARE SERVICES

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MRI REFERRAL

Patient Name: _____ Date of Request: DD / MM / YY

Patient Address: _____

Date of Birth: DD / MM / YY Phone Cell: _____ Work: _____ Home: _____

Email: _____

Appointment Date: DD / MM / YY Time: _____ Lahey Clinic # _____

Insurance Company: _____ Policy Number: _____ Certificate Number: _____

HEAD

- ☐ BRAIN
- ☐ SELLA
- ☐ ORBITS
- ☐ IAMS
- ☐ OTHER _____

MRA HEAD

- ☐ HEAD
- ☐ NECK
- ☐ CHEST
- ☐ ABDOMEN

SPINE

- ☐ CERVICAL
- ☐ SOFT TISSUE NECK
- ☐ THORACIC
- ☐ LUMBAR
- ☐ SACRUM
- ☐ OTHER _____

ABDOMEN

- ☐ LIVER
- ☐ PANCREAS
- ☐ KIDNEY
- ☐ ADRENALS
- ☐ AORTA
- ☐ OTHER _____

UPPER EXTREMITY

- ☐ SHOULDER ☐ R ☐ L
- ☐ SCAPULA ☐ R ☐ L
- ☐ HUMERUS ☐ R ☐ L
- ☐ ELBOW ☐ R ☐ L
- ☐ FOREARM ☐ R ☐ L
- ☐ WRIST ☐ R ☐ L
- ☐ HAND ☐ R ☐ L
- ☐ FINGER ☐ R ☐ L
- ☐ OTHER _____

LOWER EXTREMITY

- ☐ HIP ☐ R ☐ L
- ☐ FEMUR ☐ R ☐ L
- ☐ KNEE ☐ R ☐ L
- ☐ TIB/FIB ☐ R ☐ L
- ☐ ANKLE ☐ R ☐ L
- ☐ FOOT ☐ R ☐ L
- ☐ TOE ☐ R ☐ L
- ☐ FEMALE PELVIS
- ☐ ORTHO PELVIS
- ☐ PROSTATE/ MALE PELVIS
- ☐ RUN OFF LEGS
- ☐ OTHER _____

IS THIS PATIENT ON DIALYSIS? ◯ YES ◯ NO

If yes, patient should have dialysis within 24 hrs after infusion of contrast.

SYMPTOMS/REASON(S) FOR MRI: _____

ICD CODE: _____

Referring Dr. _____ **Phone Office:** _____ **Cell:** _____

Signature: _____ Fax: _____