iCare Diagnostic Imaging, LLC

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Date: ____________________

scheduling@icaremri.com
www.icaremri.com

Patient Name: ______________________ Phone: ______________ DOB: __________ ☐ Male ☐ Female

Referring Physician: ______________ Phone #: ______________ Fax: ______________ Email: ______________

Working Diagnosis: ICD ________________________________

Attorney : ______________________ Phone: ______________________

Insurance Company: ______________________ Claim Number/ID: ______________________

Adjuster: ______________________ Phone: ______________________

☐ Send CD with Patient ☐ Set up Online Viewing ☐ FAX Report – Fax #: ______________________

Alerts: ☐ Pacemaker ☐ Implated Device(s) ☐ Metal Braces ☐ Metal in Body (where): ______________

Reason For Exam: ☐ Confirm ☐ Rule Out ☐ Evaluate

☐ Disc Injury ☐ Stenosis ☐ Tumor/Growth ☐ Degeneration ☐ Muscle/Tendon Injury ☐ Other ______________

MRI

☐ Brain	☐ Chest		☐ Hip	L - R
☐ Cervical Spine	☐ Shoulder	L - R	☐ Knee	L - R
☐ Thoracic Spine	☐ Elbow	L - R	☐ Ankle	L - R
☐ Lumbar Spine	☐ Wrist	L - R	☐ Foot	L - R
☐ Pelvis	☐ Hand	L - R	☐ Other __________	

Pain Management/Injections

☐ Pain Management Consulting ☐ Joint Injection

☐ Trigger Point Injection ☐ PRP (Platelet-Rich Plasma)

X-Rays Upright & Weight Bearing

Cervical Spine	Thoracic Spine	Lumbar Spine	Upper/Lower Extremities	
☐ Davis Trauma Series (7 views)	☐ APT	☐ APLP	☐ Shoulder L - R	☐ Hip L - R
☐ APOM	☐ LT	☐ LLS	☐ Elbow L - R	☐ Knee L - R
☐ APLC	☐ PA-Chest	☐ Lumbosacral Spot	☐ Wrist L - R	☐ Ankle L - R
☐ LCN	☐ LAT-Chest	☐ Obliques	☐ Hand L - R	☐ Foot L - R
☐ LCF/LCE	☐ Ribs: __________	☐ Other: __________	☐ Other __________________	
☐ Obliques				

Significant History, Symptoms and Clinical Findings: ________________________________

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Type of Trauma: ☐ Auto Injury ☐ Work Injury ☐ Slip & Fall ☐ Other ______________

☐ Neck Pain ☐ Thoracic Pain ☐ Decreased ROM ☐ Sciatica/Leg Tingling/Numbness/Pain

☐ Lumbar Pain ☐ Headache/Dizziness ☐ Arm Tingling/Numbness/Pain ☐ Muscle Spasm

Date of Trauma: ____________________ History of surgery/malignancy: ☐ YES ☐ NO

Physician Signature: ____