iCare Diagnostic Imaging, LLC

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Date: ______________________

scheduling@icaremri.com

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Patient: ________________________________ Phone:___________________________ DOB: ____________ ☐ M ☐ F

Ref.Physician:___________________________Phone:_____________________________Fax:___________________________

Email:_____________________________ Working Diagnosis:ICD ____

Attorney:__________________________ Phone:________________________ Insurance Co:_________________________

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__________

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: ____