



345 Seaview Avenue
 Staten Island, NY 10305
 TEL: 718 980-4888
 FAX: 718 980-4873
AtlanticRadiology@GMail.com
 ARIMRI.COM

ATLANTIC RADIOLOGIC IMAGING

MRI REQUEST FORM

Patient Name _____
Last First

Date _____

Patient Phone _____

Referring Physician _____
Last First

UPIN# _____

Phone () _____

Signature _____

Indication (ICD-9) _____

Pre Authorization Number _____

Diagnosis/Comments and Special Requests/Views _____

CHECK PROCEDURE

MRI	
<u>HEAD</u>	
<input type="checkbox"/> Posterior Fossa	
<input type="checkbox"/> Pituitary Gland	
<input type="checkbox"/> Brain	
<u>EXTREMITIES</u>	
Right	Left
Shoulder <input type="checkbox"/>	<input type="checkbox"/>
Elbow <input type="checkbox"/>	<input type="checkbox"/>
Wrist <input type="checkbox"/>	<input type="checkbox"/>
Hip <input type="checkbox"/>	<input type="checkbox"/>
Knee <input type="checkbox"/>	<input type="checkbox"/>
Ankle <input type="checkbox"/>	<input type="checkbox"/>
Foot <input type="checkbox"/>	<input type="checkbox"/>
Other _____	
<u>SPINE</u>	
<input type="checkbox"/> C. Spine	
<input type="checkbox"/> T. Spine	
<input type="checkbox"/> L. Spine	
<u>PELVIS</u>	
<input type="checkbox"/> General	
<input type="checkbox"/> Gynecologic	

