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ATLANTIC RADIOLOGIC IMAGING

NEUROLOGIC MRI REQUEST FORM

Patient Name: _____ Date of Birth: _____
Account Number: _____ Height/Weight: _____ Home Phone: _____
Insurance: _____ Policy ID#: _____ Group#: _____
MRI appointment date: _____ Call to schedule appointment: _____
Nature/Cause of Injury: _____
Diagnosis/ICD-9 Code: _____ Previous MRI/Surgery: _____

Magnetic Resonance Imaging (MRI) *(Please check all that apply)*

HEAD & NECK

- BRAIN
- IAC'S
- NASOPHARYNX
- NECK (Soft Tissue)
- ORBITS
- OROPHARYNX
- PITUITARY
- POSTERIOR FOSSA
- SINUSES
- TEMPORAL BONES
- TMJ
- MRA Circle of Willis
- MRA Carotids

SPINE

- CERVICAL
- THORACIC
- LUMBAR

Comments _____

PLEASE SPECIFY With or Without Contrast

Referring Physician Signature: _____