OLYMPIA MRI

128 Lilly Rd NE, Suite 101, Olympia, WA 98506
Phone: 360-464-6030 Fax: 360-464-6000

MRI REFERRAL FORM

Today's Date: _____

Patient Information: (To be filled out by doctor's office)

Patient's Name (Last, First, MI):_____ Birth Date: _____

Patient's Address: _____City, State, Zip_____

Phone Numbers: Home: _____ Work:_____ Cell: _____

MRI Information: (to be completed by referring physician medical staff)

Contrast at discretion of Radiologist ☐ Yes

☐ Brain ☐ w/o ☐w/	☐ Cervical ☐ w/o ☐ w/	☐ Shoulder RT LT	☐ Pelvis ST or Bony
☐ MRA Circle of Willis	☐ Thoracic ☐ w/o ☐ w/	☐ Elbow RT LT	☐ TMJ
☐ Orbits ☐ w/o ☐w/	☐ Lumbar ☐ w/o ☐ w/	☐ Wrist/Hand RT LT	☐ Misc._____
☐ MRA Neck vessels w/o w/	☐ ST Neck	☐ Knee RT LT	☐*GFR/Creatinine_____
☐ MRV	☐ Brachial Plex ☐ w/o☐ w/	☐ Foot/Ankle RT LT	

(For Contrast Studies) GFR/Creatinine for all pt.'s with a hx of kidney disease or over the age of 60.

DX Codes/Symptoms: _____

What is suspected or being ruled out _____

Name of Practice: _____

Referring Doctor: _____ NPI # _____

Physician Signature: _____ Phone: _____ Fax: _____

PLEASE HAVE PATIENT BRING INSURANCE CARDS/INFO TO THEIR APPOINTMENT

INSURANCE INFORMATION:

Insurance Company:_____ Insurance Effective Date:_____

Authorization Code:_____ Comments:_____

☐ Department of Labor and Industries – Washington ☐ Casualty/WC/Legal /Other _____

L&I Claim Number: _____Claims Mng. _____Phone:_____DOI: _____

IS THIS AN ☐ MVA? ☐ PIP coverage? Adj. Name and Phone#: _____

If MVA, does patient have secondary insurance _____

☐ Send Report ☐ Deliver CD ☐ Patient to return with CD

Please notify Olympia MRI if patient weighs over 350 lbs./ NO pacemakers/ Brain Aneurysm Clips

Please Fax this completed form to Olympia MRI at 360-464-6000. THANK YOU!