Hawaii's MRI Leader

Phone: 808.593.8080
Fax: 808.593.1018
1010 S. King St. #109
Honolulu, HI 96814

MRI REQUEST FORM

APPOINTMENT

❍ Patient to hand carry films
❍ Patient to hand carry CD
❍ Fax report only

Date ____________________ Time ________________ ❍ am ❍ pm

❍ Call patient to schedule Name of person scheduling appointment ______________________________

PATIENT INFORMATION

Last name ________________________________ First name ______________________________________

Home/Cell phone____________________ Work phone____________________ Birth date _ _ /_ _ /_ _

INSURANCE INFORMATION

Insurance Carrier ________________________________ Authorization #____________________________

If it's Worker's Comp/Auto, please fill out the following:

Date of Accident _ _ /_ _ /_ _ ❍ Worker's Comp. ❍ Auto

Claim # ____________________________________ Employer ______________________________________

TYPE OF EXAMINATION REQUESTED

HEAD & NECK
- ❍ Brain
- ❍ IAC's
- ❍ Pituitary
- ❍ Orbits
- ❍ Face
- ❍ Neck (soft tissue or nasopharynx)

MRA or MRV
- ❍ Intracranial (head)
- ❍ Extracranial (neck)
- ❍ Other (specify:____________________)

MUSCULOSKELETAL
- ❍ Joint (specify:____________________)
- ❍ Other (specify:____________________)

SPINE
- ❍ Cervical
- ❍ Thoracic
- ❍ Lumbar
- ❍ Sacrum
- ❍ Previous spine surgery (specify:______________________)

IV CONTRAST
- ❍ Yes
- ❍ No
- ❍ Per Radiologist

OTHER ______________________________

DIAGNOSIS OR REASON FOR EXAM

(this information must be provided) ICD9 Code____________________

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REQUESTING PHYSICIAN

______________________________MD Phone #______________________

Copy of report to ____

PHYSICIAN'S SIGNATURE (REQUIRED) ____