



- ARLINGTON
- DALLAS
- DESOTO
- FORT WORTH
- Send CD with Patient

Central Scheduling: Phone: 817-226-1800 • Fax: 817-226-1802
or email your referral to referral@mrioftx.com

Date _____	Transportation <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No
Patient Name _____	D.O.I. _____	D.O.B. _____	
Address _____		City, State & Zip _____	
Patient Phone # _____	Email _____		
Referring Physician _____	Diagnosis Code(s) _____		
Physician's Signature _____	Contact Name _____		
In making this referral, the referring physician certifies that it is medically necessary.			
Office Phone # _____	Fax # _____	Email _____	
Insurance Provider _____	Phone # _____		
Legal Representative _____	Phone # _____		

ARRIVE AT OFFICE 15 MINUTES PRIOR TO YOUR EXAM TIME. PLEASE BRING YOUR INSURANCE CARD & PROPER IDENTIFICATION.
Weight: _____ IMPORTANT: Please let us know if you weigh over 300 lbs. or have any metal objects in your body.

MAGNETIC RESONANCE IMAGING (MRI)	X-RAY	CT SCAN
<input type="checkbox"/> Closed MRI <input type="checkbox"/> Open MRI Select Body Part Below: <input type="checkbox"/> With <input type="checkbox"/> Without <input type="checkbox"/> With & Without Contrast Contrast Contrast <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Head / Brain <input type="checkbox"/> Knee <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Hip <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Shoulder <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Hand <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Wrist <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Elbow <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Other _____	<input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Chest <input type="checkbox"/> Ribs <input type="checkbox"/> Ankle <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Foot <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Knee <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Wrist <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Hip <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Hand <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Shoulder <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Elbow <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Pelvis <input type="checkbox"/> ABD/KUB <input type="checkbox"/> Other _____	<input type="checkbox"/> With <input type="checkbox"/> Without <input type="checkbox"/> With & Without Contrast Contrast Contrast <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Chest <input type="checkbox"/> Head/Brain <input type="checkbox"/> Pelvis <input type="checkbox"/> ABD <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Hip <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Shoulder <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Hand <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Wrist <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Elbow <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Other _____

MYELOGRAM
<input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> Thoracic <input type="checkbox"/> Complete Spine

ARTHROGRAM
<input type="checkbox"/> Knee <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> Shoulder <input type="checkbox"/> RT <input type="checkbox"/> LT <input type="checkbox"/> With MRI <input type="checkbox"/> With CT <input type="checkbox"/> Other _____

Special Comments: