MRI Centers Of Texas

MRI • X-Ray • CT

Central Scheduling: Phone: (817) MRI-Of-TX (674-6389) • Fax: (817) 529-7250
or email your referral to referral@mrioftx.com

Date _____ **Transportation** □**Yes** □**No** □**Male** □**Female** **Pregnant** □**Yes** □**No**

Patient Name _____ D.O.I. _____ D.O.B. _____

Address _____ City, State & Zip _____

Patient Phone # _____ Email _____

Referring Physician _____ ICD-10 Code(s) _____

Physician's Signature **(required)** _____ 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 weight over 300 lbs. or have any metal objects in your body

MAGNETIC RESONANCE IMAGING (MRI)

Select Body Part Below:

	□With Contrast	□Without Contrast	□With & Without Contrast
□Cervical Spine			
□Thoracic Spine			
□Lumbar Spine			
□Head / Brain			
□Knee		□RT	□LT
□Hip		□RT	□LT
□Shoulder		□RT	□LT
□Hand		□RT	□LT
□Wrist		□RT	□LT
□Elbow		□RT	□LT
□Abdomen			
□Pelvis			

□Other _____

X-RAY

Select Body Part Below:

□Cervical Spine		
□Thoracic Spine		
□Lumbar Spine		
□Chest		
□Ribs		
□Ankle	□RT	□LT
□Foot	□RT	□LT
□Knee	□RT	□LT
□Wrist	□RT	□LT
□Hip	□RT	□LT
□Hand	□RT	□LT
□Shoulder	□RT	□LT
□Elbow	□RT	□LT
□Pelvis		

□Other _____

Special Instructions:

Maps & Locations on Reverse Side

www.MRICentersofTexas.com