☐ Houston (South)

☐ Houston (North)

MRI Centers Of Texas

MRI • X-Ray • CT

Central Scheduling: Phone: (832) 956-1800 • Fax: (832) 956-1802
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 _____ 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 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

☐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		
☐ABD/KUB		
☐Other		

CT SCAN

	☐With Contrast	☐Without Contrast	☐With & Without Contrast
☐ Cervical Spine			
☐ Thoracic Spine			
☐ Lumbar Spine			
☐ Chest			
☐ Head/Brain			
☐ Pelvis		☐ ABD	
☐ Knee			
☐ Ankle			
☐ Hip		☐RT	☐LT
☐ Shoulder		☐RT	☐LT
☐ Hand		☐RT	☐LT
☐ Wrist		☐RT	☐LT
☐ Elbow		☐RT	☐LT
☐ Other			

Special Instructions:

Maps & Locations on Reverse Side

www.MRICentersofTexas.com