☐ **SAN ANTONIO**
☐ **Send CD with Patient**

Central Scheduling: Phone: (844) MRI-OF-TX • Fax: (210) 569-7799
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