

CRYSTAL RIVER MRI

Phone: 352-437-8005 Fax: 352-228-4323

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www.crystalrivermri.com Patient Name: _____ DOB:_____ Patient Phone: _____ Insurance: ____ Diagnosis / Symptoms: _____ Physician Signature: ______ Date: _____ DIGITAL X-RAY HIGH-FIELD OPEN MRI MRA - MRV □ Abdomen □ w/o Contrast □ Abdomen □ KUB 1V \square w/ Contrast ☐ Brain - MRA □ w/ and w/o Contrast _____ ☐ Flat/Upright 2V \square w/o Contrast ☐ Series 3V □ Abdomen \square w/ and w/o Contrast □ Brain ☐ Cervical ☐ Brain - MRV □ 3V □ 5V □ F/E □ SWI ☐ Carotid Artery ☐ Chest 2V □ w/o Contrast □ Clavicle ☐ TBI Protocol \square w/ and w/o Contrast ☐ Hip 2V ☐ Breast-Bilateral □ MRCP \square R \square L ☐ Cervical ☐ Renal Artery □ Lumbar ☐ ALAR Ligament ☐ Other: \square 3V \square 5V \square Bend □ Chest □ Neck (Soft Tissue) □ Face □ Pelvis 1/2V \square IAC ☐ Rib Series □ Lumbar SPECIAL REQUESTS \square R \square L □ Neck (Soft Tissue) □ Sacrum / Coccyx □ STAT EXAM □ Orbits Scapula □ Pelvis ☐ STAT AFTER HOURS: Skull □ Bony SI Joints CALL:_____ □ Soft Tissue Sinus Series ☐ Pituitary ☐ Thoracic ☐ Thoracic PHONE:____ □ 2V □ 3V ☐ TMJ-Bilateral ☐ Upper Extremity □ Upper Extremity \square R \square L \square R \square L □ PLEASE CONTACT Area: PATIENT TO SCHEDULE Area: □ Lower Extremity ☐ Lower Extremity PHONE: \square R \square L \square R \square L Area: Area:

SPECIAL INSTRUCTIONS:		

PATIENT INSTRUCTIONS

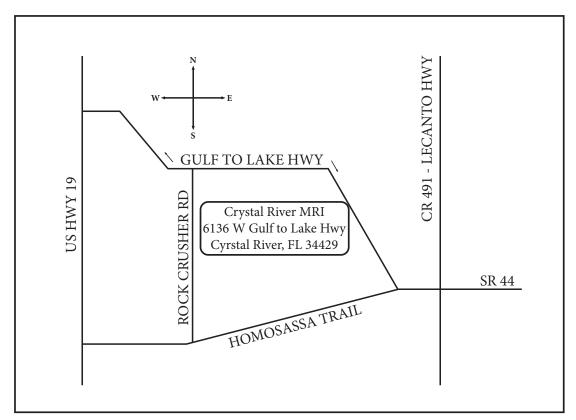
Please bring all prior images and reports at time of appointment.

Please arrive 15 minutes prior to appointment time.

Please call if you have any questions, concerns or unable to make appointment.

MRI

- Patients with implanted devices; *Pacemakers, Defibrillators, Stimulators, Pain Pumps, Stents or Aneurysm Clips* are **required to bring the vendor provided card.**
- Patients with Glucose Monitors, please inform our staff when scheduling. Most Patch Monitors will need to be removed prior to exam.





Crystal River MRI 6136 W Gulf to Lake Hwy. Crystal River, FL 34429

SCHEDULE TODAY

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Web: www.cyrstalrivermri.com

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