☐PRIORITY: **FAX WHEN READ**
☐CALL IN STAT RESULTS
Phone: ( )_____.

Email: scheduling@mdsimaging.com
Phone: (678) 935-9800
Fax: (678) 935-9836

Patient Name: _____ Date of Birth: _____

Telephone: (Primary) _____ (Secondary) _____ Email: _____

Date of Injury: _____ Type of Case: ☐MVA ☐WC ☐OTHER_____ Attorney: _____

Insurance Carrier: _____ ID#: _____ Group: _____

DIAGNOSIS (Required): _____

Referring Provider (Print): _____ Phone: _____

Provider Signature: _____ Fax: _____

PRECAUTIONS or CONCERNS: _____

MRI

☐Brain
☐Brain w/DTI
☐Orbits
☐Cervical Spine
☐Thoracic Spine
☐Lumbar Spine
☐Chest
☐Abdomen
☐Pelvis
☐Other_____

☐Knee ○Left ○Right ○Bilateral
☐Hip ○Left ○Right ○Bilateral
☐Shoulder ○Left ○Right ○Bilateral
☐Ankle ○Left ○Right ○Bilateral
☐Foot ○Left ○Right ○Bilateral
☐Wrist ○Left ○Right ○Bilateral
☐Hand ○Left ○Right ○Bilateral

REMINDER: Contact us if you are unable to make your appointment.

PATIENT CHECKLIST

- Wear comfortable clothing and try to avoid metal clasps, buttons, snaps, etc.
- If possible, remove any loose metallic objects including hair pins or piercings.
- Bring insurance card and valid photo ID to the appointment.
- Let us know about any prior imaging studies.

The facility does not have childcare. Please make prior arrangements.