



American Health Imaging of Tallahassee
 2510 Miccosukee Road, Suite 100
 Tallahassee, FL 32308
 Phone: 850-942-1100
 Fax: 850-942-1144

APPOINTMENT DATE ____/____/____ ____ AM / PM
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Please fax a copy of the patient's insurance information and any applicable clinical notes.

Patient Name: _____ DOB: _____ Height: _____ Weight: _____

Phone/Home#: _____ Work/Other#: _____ Insurance Provider: _____

Ins. Group#: _____ Ins. Member#: _____ Precert/Auth#: _____

Referring Physician: _____ Contact Person: _____

Physician Phone#: _____ Physician Fax#: _____

HEAD & NECK MRI			ORTHO MRI			BODY MRI		
	WITH CONTRAST	WITHOUT CONTRAST					WITH CONTRAST	WITHOUT CONTRAST
<input type="checkbox"/> Brain	_____	_____	<input type="checkbox"/> Finger/Thumb L R	_____	_____	<input type="checkbox"/> Sacrum/Coccyx	_____	_____
<input type="checkbox"/> IAC'S	_____	_____	<input type="checkbox"/> Hand L R	_____	_____	<input type="checkbox"/> MRCP	_____	_____
<input type="checkbox"/> Pituitary-Sella	_____	_____	<input type="checkbox"/> Wrist L R	_____	_____	<input type="checkbox"/> Chest	_____	_____
<input type="checkbox"/> Orbits	_____	_____	<input type="checkbox"/> Forearm L R	_____	_____	<input type="checkbox"/> Abdomen	_____	_____
<input type="checkbox"/> TMJ	_____	_____	<input type="checkbox"/> Elbow L R	_____	_____	<input type="checkbox"/> Renal	_____	_____
<input type="checkbox"/> Soft Tissue Neck	_____	_____	<input type="checkbox"/> Humerus L R	_____	_____	<input type="checkbox"/> Enterography	_____	_____
<input type="checkbox"/> Cranial Nerves	_____	_____	<input type="checkbox"/> Shoulder L R	_____	_____	<input type="checkbox"/> Brachial Plexus	_____	_____
MRA			<input type="checkbox"/> Scapula L R	_____	_____	<input type="checkbox"/> Pelvis (bony)	_____	_____
<input type="checkbox"/> Circle of Willis (Head)	_____	_____	<input type="checkbox"/> Foot L R	_____	_____	<input type="checkbox"/> Pelvis (soft tissue)	_____	_____
<input type="checkbox"/> Carotids/Vertebrals	_____	_____	<input type="checkbox"/> Ankle L R	_____	_____	SPINE MRI		
<input type="checkbox"/> Renal	_____	_____	<input type="checkbox"/> Knee L R	_____	_____	<input type="checkbox"/> Cervical	_____	_____
			<input type="checkbox"/> Hip L R	_____	_____	<input type="checkbox"/> Thoracic/Dorsal	_____	_____
			<input type="checkbox"/> Thigh L R	_____	_____	<input type="checkbox"/> Lumbar	_____	_____
			<input type="checkbox"/> Lower Leg L R	_____	_____			

CT SCANS								
	WITH CONTRAST	WITHOUT CONTRAST		WITH CONTRAST	WITHOUT CONTRAST		WITH CONTRAST	WITHOUT CONTRAST
<input type="checkbox"/> Brain	_____	_____	<input type="checkbox"/> Abdomen/Pelvis	_____	_____	<input type="checkbox"/> CTA Head	_____	_____
<input type="checkbox"/> Facial Bones	_____	_____	<input type="checkbox"/> Abdomen/Pelvis - Kidney Stone	_____	_____	<input type="checkbox"/> CTA Neck	_____	_____
<input type="checkbox"/> Sinuses	_____	_____	<input type="checkbox"/> Brachial Plexus	_____	_____	<input type="checkbox"/> Cervical Spine	_____	_____
<input type="checkbox"/> Sinus Stealth	_____	_____	<input type="checkbox"/> Enterography	_____	_____	<input type="checkbox"/> Thoracic Spine	_____	_____
<input type="checkbox"/> IAC's	_____	_____	<input type="checkbox"/> Enterography	_____	_____	<input type="checkbox"/> Lumbar Spine	_____	_____
<input type="checkbox"/> Orbits	_____	_____	<input type="checkbox"/> CTA Pulmonary	_____	_____	<input type="checkbox"/> Chest	_____	_____
<input type="checkbox"/> Abdomen	_____	_____	<input type="checkbox"/> CTA - Abdomen/Pelvis (AAA)	_____	_____	<input type="checkbox"/> Soft Tissue Neck	_____	_____
<input type="checkbox"/> Pelvis	_____	_____	<input type="checkbox"/> CTA Chest - Aneurysm	_____	_____	<input type="checkbox"/> Extremities ____ L R	_____	_____
						<input type="checkbox"/> Other _____	_____	_____

ULTRASOUND		
<input type="checkbox"/> Abdomen, Complete	<input type="checkbox"/> Pelvic with Transvaginal	<input type="checkbox"/> Lower Extremity Venous R L
<input type="checkbox"/> Abdomen, Limited, Quadrant _____	<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/> Upper Extremity Venous R L
<input type="checkbox"/> Renal	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Carotid
<input type="checkbox"/> Aorta	<input type="checkbox"/> Scrotum	<input type="checkbox"/> Renal Doppler
<input type="checkbox"/> Pelvic, Complete, Non-OB	<input type="checkbox"/> Extremity Non Vascular	<input type="checkbox"/> Hepatic with Doppler

Report Only CD Films Images w/PT STAT

ICD-10 Code / Diagnosis: _____

Special Instructions: _____

Physician Signature: _____ Date: _____

FREE TRANSPORTATION • FREE PARKING • SAME DAY APPOINTMENTS • NEXT DAY RESULTS



HIGH-QUALITY DIAGNOSTIC IMAGING FOR PERSONAL INJURY PATIENTS

State-of-the-Art MRI Equipment

- 1.5T High-Field, Wide-Bore MRI
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 - Darr McKeown, MD
 - Thomas Brown MD
 - Ravi Yarlagadda, MD

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- WARP – Artifact reduction technology
- BLADE – Motion reduction technology
- DTI – Diffusion Tensor Imaging for TBI cases
- SWI – For proof of Cerebral Hemorrhage
- NeuroQuant – measures volumes of brain structures and compares to norms

For Personal Injury Scheduling:

850-942-1100 or Fax: 850-942-1144



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Call 855-MRI-CHOICE or visit AmericanHealthImaging.com