REFERRAL REQUEST

Coosa Valley MRI, LLC
315 W. Hickory St.
Sylacauga, AL 35150
(P) 256.207.2686 • (TF) 866.358.9492
(F) 256.207.2551

Appt. Date _____

Arrival Time _____

Scan Time _____

☐ Call Patient to Schedule

☐ Pre-cert (Must Send Clinical Notes)

PATIENT INFORMATION

Patient Name: _____ Sex: ☐M ☐F D.O.B. _____ SS# _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Primary Insurance: _____ Policy No.: _____ Group No.: _____

Secondary Insurance: _____ Policy No.: _____ Group No.: _____

Pre-Certification Approval No. (s) _____

REFERRING PHYSICIAN INFORMATION

Referring Physician (Print): _____ Office Contact: _____

Office Phone: ( ) _____ Office Fax: ( ) _____ MD Backline or Pager: _____

CLINICAL INFORMATION

Diagnosis: _____

Special Instructions: _____

☐ FAX REPORT ☐ STAT REPORT ☐ CALL REPORT ☐ SEND FILM W/PT ☐ SEND FILM BY US MAIL ☐ SEND CD W/PT ☐ SEND CD BY US MAIL

REFERRING PHYSICIAN SIGNATURE: _____

(FEDERAL LAW REQUIRES ORIGINAL SIGNATURE OF REFERRING PHYSICIAN)

MRI/MRA PROCEDURE

CPT	X	MRI					
74181		ABDOMEN WO	☐ MRCP (GALLBLADDER) NPO 8 hrs				
74181		ABDOMEN WO	☐ LIVER	☐ KIDNEY	☐ ADRENAL	☐ PANCREAS	(can have light meal)
74183		ABDOMEN W/WO	☐ LIVER	☐ KIDNEY	☐ ADRENAL	☐ PANCREAS	(can have light meal)
73222		ARTHROGRAM UPPER EXTREMITY JOINT W	☐ Right	☐ Left	☐ Shoulder	☐ Elbow	☐ Wrist
73722		ARTHROGRAM LOWER EXTREMITY JOINT W	☐ Right	☐ Left	☐ Hip	☐ Knee	☐ Ankle
70551		BRAIN WO					
70553		BRAIN W/WO					
72141		CERVICAL SPINE WO					
72156		CERVICAL SPINE W/WO					
70553-59		IAC W/WO					
73718		LOWER EXTREMITY WO	☐ Right	☐ Left	☐ Femur	☐ Tib/Fib	☐ Foot
73720		LOWER EXTREMITY W/WO	☐ Right	☐ Left	☐ Femur	☐ Tib/Fib	☐ Foot
73721		LOWER EXTREMITY JOINT WO	☐ Right	☐ Left	☐ Hip	☐ Knee	☐ Ankle
73723		LOWER EXTREMITY JOINT W/WO	☐ Right	☐ Left	☐ Hip	☐ Knee	☐ Ankle
72148		LUMBAR SPINE WO					
72158		LUMBAR SPINE W/WO					
70543		ORBIT W/WO (Radiologist request a second order of brain W/WO)					
72195		PELVIS WO					
72197		PELVIS W/WO					
70553-59		PITUITARY W/WO					
70540		SOFT TISSUE NECK WO					
70543		SOFT TISSUE NECK W/WO					
72146		DORSAL SPINE WO					
72157		DORSAL SPINE W/WO					
70336		TMJ WO					
73218		UPPER EXTREMITY WO	☐ Right	☐ Left	☐ Upper Arm	☐ Forearm	☐ Hand
73220		UPPER EXTREMITY W/WO	☐ Right	☐ Left	☐ Upper Arm	☐ Forearm	☐ Hand
73221		UPPER EXTREMITY JOINT WO	☐ Right	☐ Left	☐ Shoulder	☐ Elbow	☐ Wrist
73223		UPPER EXTREMITY JOINT W/WO (Not Arthrogram)	☐ Right	☐ Left	☐ Shoulder	☐ Elbow	☐ Wrist ☐ Brachial

MRA				OTHER UNLISTED PROCEDURES
70544		HEAD WO	☐ MRV	
70549		NECK W/WO (preferred)		
70547		NECK WO (Choose only if contrast contraindicated)		
74185		ABDOMEN W	☐ RENAL ARTERIES	☐ MESENTERIC ARTERY

PATIENT INSTRUCTIONS

1. **Please bring physician signed referral to your appointment.**
2. **Please bring all insurance cards, photo ID, and list of your medications.**
3. **Unless otherwise instructed by your physician, take your daily medications (including pain medication).**
4. **Please leave all jewelry and unnecessary valuables at home.**
5. **Remove all metal objects before your exam.**
6. **Please advise MRI personnel if you have any of the following: pacemaker, ear implants, aneurysm clips, metal fragments in one or both eyes, pain pump implant, spinal cord stimulator, or any other implant.**
7. **Please contact us 24 hours in advance if you are unable to keep your appointment.**
8. **Call us with any questions you may have regarding your exam or visit our website at www.coosavalleymri.com**
9. **Visit our website for patient forms, directions to our facility, and a general overview of our company at www.coosavalleymri.com**

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