EXTREMITY MRI ORDER FORM

Contact us toll free:

Call **1-866-398-7364** or *Fax* **1-866-267-0144**

Thank you for choosing EIP!

Excellence in Extremity MRI

Tax ID **04-3627188** NPI **1528058245**

Patient's Name _____ Date _____

Patient's Phone (_____)_____ DOB _____ ❑ Male ❑ Female

Insurance Name _____

MRI ORDER FOR	LEFT	RIGHT	BOTH
Forefoot			
Midfoot			
Hindfoot/Ankle			
Lower Leg			
Knee			
Hand			
Wrist			
Lower Arm			
Elbow			

Note **SPECIFIC AREA OF INTEREST**

_____

_____

_____

Note **CURRENT DIAGNOSIS or REASON FOR TREATMENT**

_____

_____

_____

Check any that apply:

- ❑ Pacemaker/Defibrillator
- ❑ Worked w/ metal, hit in face/eyes w/ metal, metal removed from face/eyes (need orbital x-rays)
- ❑ Recent surgery in area of interest (fax op report)
- ❑ Implanted device (ex, cochlear implants, bone stimulators, pins/screws, etc.)
- ❑ Heart valve/stent (need card or op report)
- ❑ Brain surgery/aneurysm clips
- ❑ Possibility of Pregnancy
- ❑ Weighs >350lbs
- ❑ Previous MRI (any kind)
- ❑ Was seen at EIP before
- ❑ **NONE APPLY**

Precert # _____

Choose an EIP Center:

- ❑ Allentown, PA (*formerly Bethlehem, PA*)
- ❑ Temple Foot & Ankle Institute (Philadelphia, PA)

Referring Dr. (print name) _____

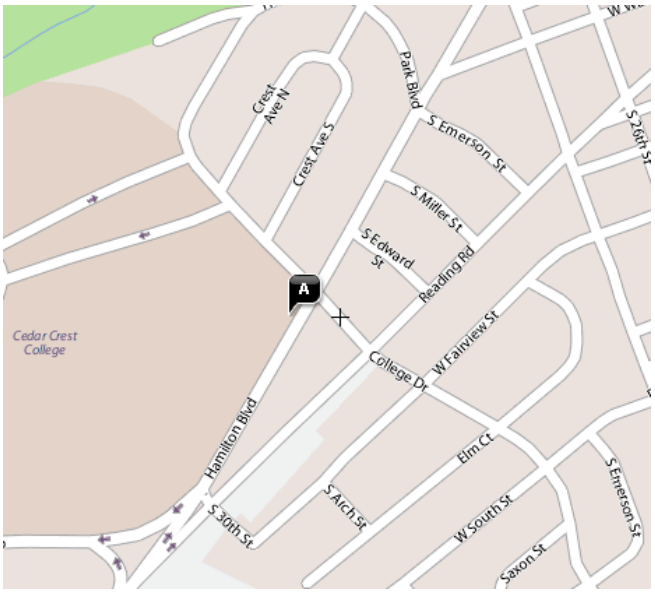
Phone (_____) _____ Fax (_____) _____

Dr. **SIGNATURE** _____

*EIP will attempt to obtain precertification for your patient's MRI, if required, granted the following clinical information is provided. The information can be noted on this order form or provided to EIP in the form of **transcribed** office notes. Thank you!*

Clinical Questions for Precertification	YES	NO	If YES, need dates	N/A	Notes
Do you have recent x-ray report results?					
Are you using meds, e.g. NSAIDS, for the condition requiring the MRI? If so, note meds & how long.					
Have you used recent or current PT or exercise programs to treat the patient?					
Is there a history of treatment for the affected area of interest, including injections? If so, note treatment					
Is there a history of related injury?					
Are there planned procedures, services (e.g., orthotics, casts, etc.) or any previous procedures. If so, note procedures.					
Have all approaches to conservative care failed? If so, note any & how long.					
Please note the patient's range of motion (both active and passive)					

DIRECTIONS



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Allentown, PA 18104
610-432-1055

PHILADELPHIA, PA
Temple Foot & Ankle Institute
8th at Race Sts., Room 3
Philadelphia, PA 19107
215-625-5279