



Excellence in Extremity MRI

Tax ID 04-3627188 NPI 1528058245

# EXTREMITY MRI ORDER FORM

Contact us toll free:

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

Thank you for choosing EIP!

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

Patient's Phone (\_\_\_\_\_) \_\_\_\_\_ DOB \_\_\_\_\_  Male  Female

Insurance Name \_\_\_\_\_

Note **SPECIFIC AREA OF INTEREST**

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

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**

**Choose an EIP Center:**

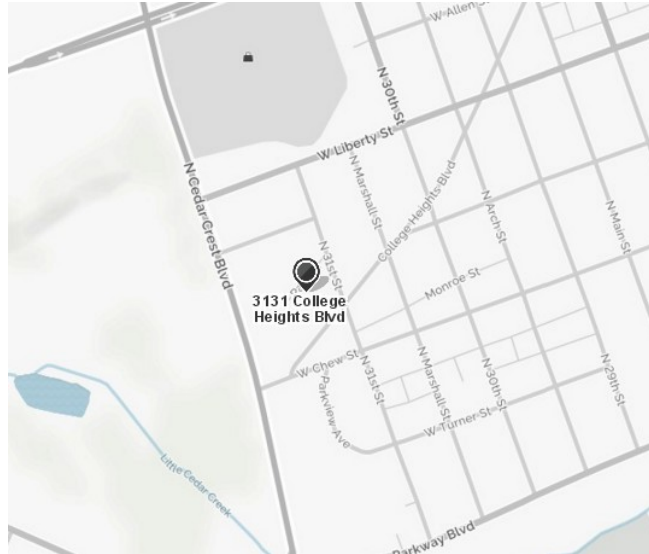
- Allentown, PA
- Temple Foot & Ankle Institute (Philadelphia, PA)

**Precert #** \_\_\_\_\_

Referring Dr. (print name) _____
Phone (_____) _____ Fax (_____) _____
Dr. <b>SIGNATURE</b> _____

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)					



**ALLENTOWN, PA**  
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3131 College Heights Blvd  
Suite 400  
Allentown, PA 18104  
**610-432-1055**



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