South Florida Imaging
Diagnostic Center Inc.

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PATIENT INFORMATION

PATIENT NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ SEX: ❑ M ❑ F ❑ MARRIED ❑ SINGLE ❑ OTHER

SOCIAL SECURITY # _____ DATE OF BIRTH _____ HOSPITALIZED ❑ YES ❑ NO PACEMAKER ❑ YES ❑ NO

DATE OF INJURY (IF APPLICABLE) _____ DATE OF 1ST DOCTOR CONSULTATION _____ TRANSPORTATION NEEDED ❑ YES ❑ NO

INSURANCE INFORMATION

INSURED _____ RELATIONSHIP _____ IF NOT SELF, THEN _____

INSURANCE COMPANY _____ TYPE: ❑ PIP ❑ MAJOR MEDICAL ❑ OTHER _____

TELEPHONE _____ ADJUSTER _____ PRIOR AUTHORIZATION (IF APPLICABLE) _____

CLAIM# _____ POLICY # _____ GROUP # _____

HEALTH OR SECONDARY INSURANCE _____ ID# _____ GROUP# _____

ATTORNEY (IF APPLICABLE) _____ ATTORNEY PHONE # _____

MRI EXAM

HEAD & NECK
- ❑ Brain
- ❑ IAC
- ❑ Neck-Soft Tissue
- ❑ Orbit
- ❑ Pituitary
- ❑ Sinuses
- ❑ TMJ R____ L____
- ❑ Other _____

SPINE
- ❑ Cervical
- ❑ Thoracic
- ❑ Lumbar
- ❑ Pelvis
- ❑ Sacrum/Coccyx
- ❑ Other _____

MUSCULOSKELETAL

UPPER EXTREMITY				LOWER EXTREMITY		
❑ Shoulder	R____	L____	❑ Hip	R____	L____	
❑ Humerus	R____	L____	❑ Femur	R____	L____	
❑ Elbow	R____	L____	❑ Knee	R____	L____	
❑ Forearm	R____	L____	❑ Tibia/Fibula	R____	L____	
❑ Wrist	R____	L____	❑ Ankle	R____	L____	
❑ Hand	R____	L____	❑ Heel	R____	L____	
❑ Finger	R____	L____	❑ Forefoot	R____	L____	
❑ Other _____			❑ Toe	R____	L____	

BODY
- ❑ Abdomen
- ❑ Brachial Plexus
- ❑ MRCP
- ❑ Pelvis-Soft tissue
- ❑ Other _____

❑ HITACHI OPEN MRI ❑ WITH AND WITHOUT CONTRAST ❑ G.E. 1.5 HIGH FIELD MRI

MRI WITH IV CONTRAST: Lab Values: BUN _____ CREAT: _____ DATE: _____
Blood work must be within 60 days of exam. Needed for all hypertensive, diabetics, kidney disease patients and anyone over 60

MRA EXAM
- ❑ Brain/Head/COW
- ❑ Brain/Head (Venous) MRV
- ❑ Chest (Thoracic, Aorta, Aortic Arch, Great Vessels)
- ❑ Neck (Carotids)
- ❑ Runoff (Aorta, Pelvis, Lower Extremity)
- ❑ Renal
- ❑ Extremity Upper Lower
- ❑ Other _____

BONE DENSITY
- ❑ Bone Density / Dexa Scan
- ❑ BMI

DIGITAL XRAY

❑ Skull			❑ A/C Joints	R____	L____
❑ Sinus	R____	L____	❑ Scapula	R____	L____
❑ Orbits	R____	L____	❑ Forearm	R____	L____
❑ Abdomen			❑ Elbow	R____	L____
❑ KUB			❑ Wrist	R____	L____
❑ Nasal	R____	L____	❑ Hand	R____	L____
❑ Chest			❑ Finger	R____	L____
❑ Ribs	R____	L____	❑ SI Joints	R____	L____
❑ Cervical			❑ Sacrum	R____	L____
❑ Thoracic			❑ Hip	R____	L____
❑ Lumbar			❑ Femur	R____	L____
❑ Pelvis	R____	L____	❑ Knee	R____	L____
❑ Sternum			❑ Tibia/Fibula	R____	L____
❑ Clavicle	R____	L____	❑ Ankle	R____	L____
❑ Humerus	R____	L____	❑ Heel	R____	L____
❑ Shoulder	R____	L____	❑ Foot	R____	L____

❑ Other _____

ULTRASOUND
- ❑ Echo 2D/Mode
- ❑ Cardiac Doppler
- ❑ Color Flow Doppler
- ❑ Carotid Duplex
- ❑ Carotid Doppler
- ❑ Peri Orbital Doppler
- ❑ Bilateral Venous Duplex (UE or LE)
- ❑ Bilateral Venous Doppler
- ❑ Unilateral Venous (UE or LE)
- ❑ IVC/ILIAC
- ❑ U E Arterial Doppler
- ❑ Art. Pressures-Multi-duplex
- ❑ Hemodialysis Access Graft
- ❑ Single Level ABI
- ❑ L E Arterial Doppler (BIL)
- ❑ L E Arterial Lower (UNI)
- ❑ Abdominal-complete
- ❑ Limited (Quad,single organ)
- ❑ Renal
- ❑ Renal Doppler
- ❑ Aorta/ILIAC/IVC Doppler
- ❑ Abd/Pelvic/Scrotal Doppler
- ❑ Limited Doppler
- ❑ Limited AO/TVC Doppler
- ❑ Pelvic/Bladder (Pre-post)
- ❑ Thyroid
- ❑ Breast
- ❑ Extremity non-vascular
- ❑ Other _____

DIAGNOSIS & MEDICAL NECESSITY _____

REFERRING PHYSICIAN _____ PHONE _____ FAX _____

PHYSICIAN'S SIGNATURE _____ LICENSE# _____ NPI# _____