HealthView
MEDICAL IMAGING

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MRI - Diagnostic Imaging Requisition

Patient Information

Name _____

Address _____ Telephone: _____

Sex _____ DOB _____ HCN# _____

Referring Physician

Name: _____ Telephone: _____ Fax: _____

Address: _____

Exam Requested _____

Indication for exam _____

Physician signature: _____ Faxed by: _____

Required Patient Information - Must be completed by Referring Physician

Pacemaker	Yes	❒	No ❒	Cerebral aneurysm clips	Yes	❒	No ❒
Metal Posthesis	Yes	❒	No ❒	Previous Surgery	Yes	❒	No ❒
Injury to eye with metal	Yes	❒	No ❒				

Pertinent Studies From Outside Institutions Should Be Made Available

HealthView Imaging Use Only

Time in _____ Time out _____

Notes: _____

Medications and/or contrasts administered: _____

Technologist _____

Date _____

Imaging Date: _____
Time: _____
CDC # _____

Charges:

MRI: _____ Contrasts: _____

CD's _____

Films _____ Total: _____

Radiologist's Instructions _____