611 MRI·CT Altoona

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PHYSICIAN REFERRAL FORM

APPOINTMENT DATE _____ TIME _____

PATIENT NAME _____

PHONE (HOME) _____ PHONE (WORK) _____

DATE OF BIRTH _____

EXAM REQUEST: _____

BODY PART TO BE SCANNED

O OPEN MRI O MRI O CT SCAN O ULTRASOUND O FLUOROSCOPY O X-RAY

O WITH CONTRAST O WITH AND WITHOUT CONTRAST O WITHOUT CONTRAST

REASON FOR EXAM (Our staff will interview patient prior to exam to obtain medical history)

_____

_____

_____

REFERRING PHYSICIAN

SIGNATURE _____

PRINT NAME _____

PHONE _____ FAX _____

INSURANCE AUTHORIZATION # _____

ALL REPORTS FAXED WITHIN 24-48 HOURS OF EXAM. PLEASE SPECIFY ANY SPECIAL REQUESTS.

611 MRI•CT ACCEPTS MOST INSURANCE PLANS. SOME INSURANCE COMPANIES REQUIRE PRE-CERTIFICATION. A SELF PAY OPTION IS AVAILABLE. PLEASE CALL WITH ANY QUESTIONS. 814-946-8000