www.611mri.com
2950 FAIRWAY DRIVE • ALTOONA, PA 16602
P: 814-946-8000 • F: 814-946-8002

Please print and fax this completed form to 814-946-8002.
For any urgent requests, please call 814-946-8000.

PHYSICIAN REFERRAL FORM

APPOINTMENT DATE ______________________ TIME ______________________

PATIENT NAME ______________________

PHONE (HOME) ______________________ PHONE (WORK) ______________________

DATE OF BIRTH ______________________

EXAM REQUEST: ______________________

BODY PART TO BE SCANNED

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

○ WITH CONTRAST ○ WITH AND WITHOUT CONTRAST ○ WITHOUT CONTRAST

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

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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

Thank you for choosing 611 MRI and for referring your patient to us.
We appreciate the opportunity to partner with you in your patient's care.