

Experimental Pulse Sequences Referral

| | | | |
|---------------------|-------------------|----------------------------|----------------------------------|
| Patient Name | Age/Gender | Referring Physician | Physician Phone & FAX |
| | | | |
| Phone Number | DOB | Height | Weight |
| | | | |

SS#

MRN #

Reason for the exam

| | | | |
|------------------------|------------|-----------------------------------|-------------------------------|
| Medical History | GFR | Currently Under Treatment? | Currently on Steroids? |
| | | yes no | yes no |
| | | | |
| | | | |
| | | | |
| | | Medications | |
| | | | |
| | | | |

| | | | |
|---------------------------------------|-------------|--------------------------|------------------------|
| Previous Neuroaxis MRI survey? | Date | Location (circle) | Report attached |
| | | WestImage | yes no |
| | | UC | |

| | | |
|--------------------------|-------------|------------------------|
| Prior Studies: | DATE | Report attached |
| Brain MRI yes no | | yes no |
| Spine MRI yes no | | yes no |
| CT Brain yes no | | yes no |
| CT Spine yes no | | yes no |

RIB CODE 309

| | |
|-----------------------------------|-------------|
| Meets Eligibility Criteria | |
| 18 years of age or older | yes no |
| Not pregnant | yes no |
| not confined to penal institution | yes no |
| Capable of lying supine 15" | yes no |
| Capable of providing consent | yes no |
| No history of Claustrophobia | yes no |
| No MRI contraindications | yes no |

Pre-authorization #