☐ Irmo (MRI, CT, DTI)
☐ Downtown Columbia (MRI, CT)
☐ West Columbia (MRI, CT)

APPOINTMENT DATE
______/______/______
__________ AM / PM

AMERICAN HEALTH IMAGING

Please fax a copy of the patient's insurance information and any applicable clinical notes.

Patient Name: ______________________ DOB: __________ Height: ________ Weight: ________

Phone/Home#: ______________ Work/Other#: ______________ Insurance Provider: ______________

Ins. Group#: ______________ Ins. Member#: ______________ Precert/Auth#: ______________

Referring Physician: ______________________ Contact Person: ______________________

Physician Phone#: ______________________ Physician Fax#: ______________________

HEAD & NECK MRI | ORTHO MRI | BODY MRI

☐ WITHOUT CONTRAST ☐ WITH CONTRAST ☐ WITH & WITHOUT CONTRAST

HEAD & NECK MRI
- ☐ Brain
- ☐ Volumetric Study
- ☐ DTI
- ☐ IAC'S
- ☐ Pituitary-Sella
- ☐ Orbits
- ☐ TMJ
- ☐ Soft Tissue Neck
- ☐ Cranial Nerves

MRA
- ☐ Circle of Willis (Head)
- ☐ Carotids/Vertebrals
- ☐ Renal

ORTHO MRI
- ☐ Finger/Thumb L R
- ☐ Hand L R
- ☐ Wrist L R
- ☐ Elbow L R
- ☐ Shoulder L R
- ☐ Scapula L R
- ☐ Foot L R
- ☐ Ankle L R
- ☐ Knee L R
- ☐ Hip L R
- ☐ Thigh L R
- ☐ Lower Leg L R

BODY MRI
- ☐ Sacrum/Coccyx
- ☐ MRCP
- ☐ Chest
- ☐ Abdomen
- ☐ Enterography
- ☐ Brachial Plexus
- ☐ Pelvis (bony)
- ☐ Pelvis (soft tissue)
- ☐ Liver

SPINE MRI
- ☐ Cervical
- ☐ Thoracic/Dorsal
- ☐ Lumbar
- ☐ Other______________

CT SCANS

☐ WITHOUT CONTRAST ☐ IV ONLY (NO ORAL) ☐ ORAL AND IV

- ☐ Brain
- ☐ Facial Bones
- ☐ Sinuses
- ☐ Sinus Stealth
- ☐ IAC's
- ☐ Pituitary
- ☐ Orbits
- ☐ Abdomen
- ☐ Pelvis
- ☐ Abdomen/Pelvis Enterography
- ☐ Abdomen/Pelvis Kidney Stone
- ☐ Urogram
- ☐ Enterography w/IV
- ☐ Extremities L R
  Specify:______________________
- ☐ CTA Pulmonary
- ☐ CTA - Abdomen/Pelvis (AAA)
- ☐ CTA Chest - Aneurysm
- ☐ CTA Head
- ☐ CTA Neck
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbar Spine
- ☐ Chest
- ☐ Soft Tissue Neck
- ☐ Renal (wo/w IV)
- ☐ Liver (wo/w IV)
- ☐ Other ________________

ATTORNEYS

Attorney Name: ______________________ Attorney Number: ______________________ Date of Injury: ______________

☐ Work Comp ☐ MVA ☐ Slip & Fall

☐ Report Only ☐ CD ☐ Images w/PT ☐ STAT

ICD-10 Code / Diagnosis: ____

Special Instructions: ____

Physician Signature: ______________________________ Date: ______________

FREE PARKING • SAME DAY APPOINTMENTS • NEXT DAY RESULTS

STATE-OF-THE-ART DIAGNOSTIC IMAGING NOW AVAILABLE IN COLUMBIA

Irmo
1245 Lake Murray Blvd, Suite B
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Fax: 803.766.3006

Downtown Columbia
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Columbia, SC 29201
Phone: 803.766.3009
Fax: 803.766.3010

West Columbia
3020 Sunset Blvd, Suite 105
West Columbia, SC 29169
Phone: 803.766.3007
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