



- Mt. Pleasant (MRI, CT, DTI)
- Summerville (MRI, CT)

<b>APPOINTMENT DATE</b> ____/____/____ _____ AM / PM
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# 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	CT SCANS
<input type="checkbox"/> WITHOUT CONTRAST	<input type="checkbox"/> WITH CONTRAST	<input type="checkbox"/> WITH & WITHOUT CONTRAST	<input type="checkbox"/> WITHOUT CONTRAST <input type="checkbox"/> IV ONLY (NO ORAL) <input type="checkbox"/> ORAL AND IV
<input type="checkbox"/> Brain <input type="checkbox"/> Volumetric Study <input type="checkbox"/> DTI <input type="checkbox"/> IAC'S <input type="checkbox"/> Pituitary-Sella <input type="checkbox"/> Orbits <input type="checkbox"/> TMJ <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Cranial Nerves <input type="checkbox"/> MRA <input type="checkbox"/> Circle of Willis (Head) <input type="checkbox"/> Carotids/Vertebrals <input type="checkbox"/> Renal	<input type="checkbox"/> Finger/Thumb L R <input type="checkbox"/> Hand L R <input type="checkbox"/> Wrist L R <input type="checkbox"/> Elbow L R <input type="checkbox"/> Shoulder L R <input type="checkbox"/> Scapula L R <input type="checkbox"/> Foot L R <input type="checkbox"/> Ankle L R <input type="checkbox"/> Knee L R <input type="checkbox"/> Hip L R <input type="checkbox"/> Thigh L R <input type="checkbox"/> Lower Leg L R	<input type="checkbox"/> Sacrum/Coccyx <input type="checkbox"/> MRCP <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Enterography <input type="checkbox"/> Brachial Plexus <input type="checkbox"/> Pelvis (bony) <input type="checkbox"/> Pelvis (soft tissue) <input type="checkbox"/> Liver <input type="checkbox"/> SPINE MRI <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic/Dorsal <input type="checkbox"/> Lumbar <input type="checkbox"/> Other _____	<input type="checkbox"/> Brain <input type="checkbox"/> Facial Bones <input type="checkbox"/> Sinuses <input type="checkbox"/> Sinus Stealth <input type="checkbox"/> IAC's <input type="checkbox"/> Pituitary <input type="checkbox"/> Orbits <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Abdomen/Pelvis Enterography <input type="checkbox"/> Abdomen/Pelvis Kidney Stone <input type="checkbox"/> Urogram <input type="checkbox"/> Enterography w/IV <input type="checkbox"/> Extremities L R Specify: _____ <input type="checkbox"/> CTA Pulmonary <input type="checkbox"/> CTA - Abdomen/Pelvis (AAA) <input type="checkbox"/> CTA Chest - Aneurysm <input type="checkbox"/> CTA Head <input type="checkbox"/> CTA Neck <input type="checkbox"/> Cervical Spine <input type="checkbox"/> Thoracic Spine <input type="checkbox"/> Lumbar Spine <input type="checkbox"/> Chest <input type="checkbox"/> Soft Tissue Neck <input type="checkbox"/> Renal (wo/w IV) <input type="checkbox"/> Liver (wo/w IV) <input type="checkbox"/> Other _____

ATTORNEYS
Attorney Name: _____ Attorney Number: _____ Date of Injury: _____ <div style="text-align: center;"> <input type="checkbox"/> Work Comp    <input type="checkbox"/> MVA    <input type="checkbox"/> Slip &amp; Fall           </div>

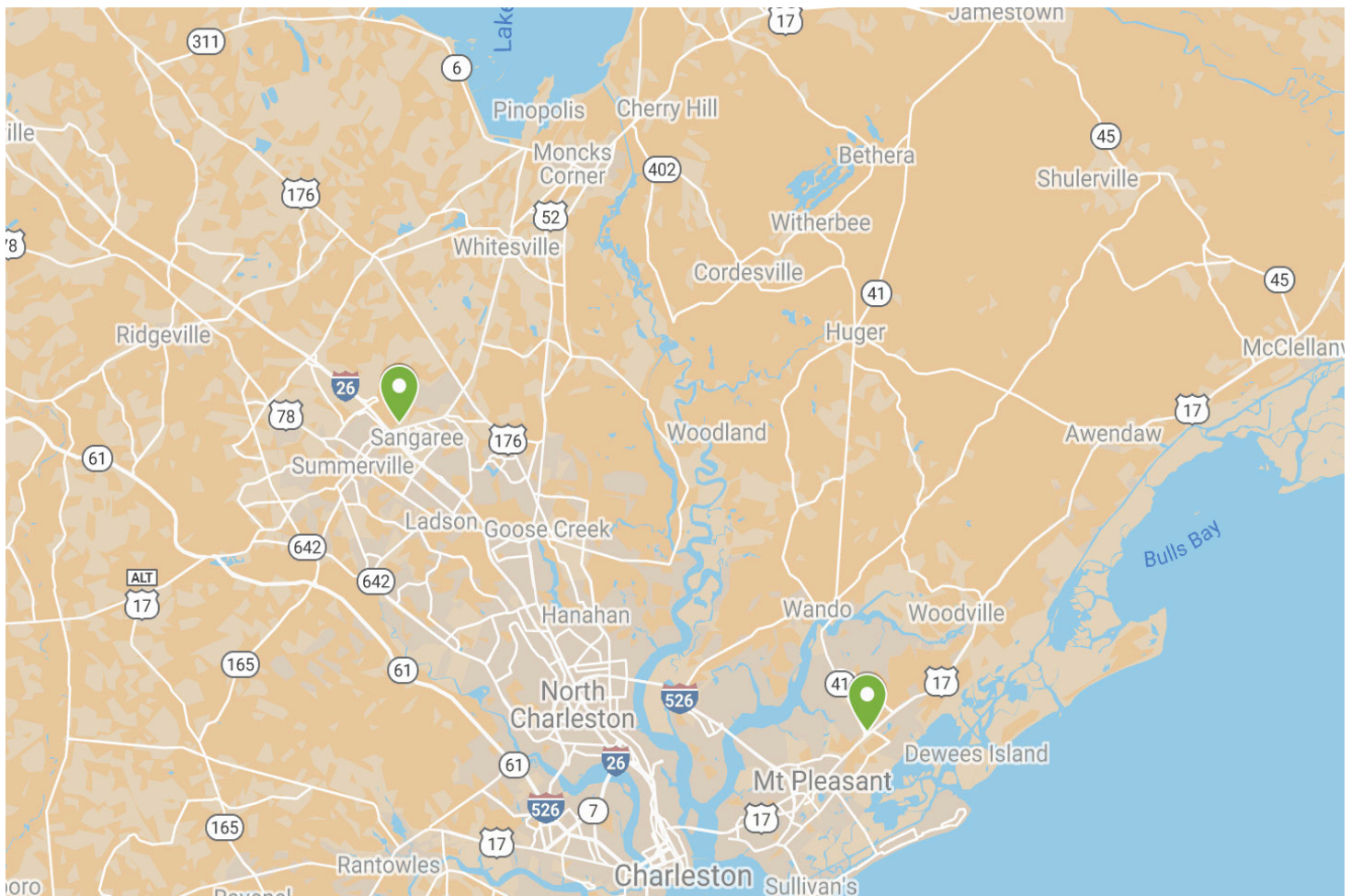
Report Only     CD     Images w/PT     STAT

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 CHARLESTON

### **Mt. Pleasant**

1172 US Highway 41, Suite 103  
Mt. Pleasant, SC 29466  
Phone: 843.999.0097  
Fax: 843.999.0551

### **Summerville**

902 Nexton Square Drive  
Summerville, SC 29486  
Phone: 843.999.0558  
Fax: 843.999.0565

**AMERICAN HEALTH**  Imaging

  
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