

Patient name: _____ Birthdate: _____

Patient phone #: _____ Other #: _____

Date and time of exam: _____ SSN _____

OPEN MRI

- Weight Limit: 400 lbs
- BRAIN
 - ORBITS
 - NECK (SOFT TISSUE)
 - CERVICAL SPINE
 - THORACIC SPINE
 - LUMBAR SPINE
 - SI JOINTS
 - SACRUM
 - SHOULDER
 - ELBOW
 - WRIST
 - HAND
 - ABDOMEN
 - PELVIS
 - HIP
 - KNEE
 - ANKLE
 - FOOT
 - OTHER _____

MRA

- HEAD
- NECK/CAROTIDS

CT

- WEIGHT LIMIT: 400 LBS.
- BRAIN
 - ORBITS
 - NECK (SOFT TISSUE)
 - TEMPORAL BONES/(IAC)
 - SINUSES
 - CERVICAL SPINE
 - THORACIC SPINE
 - LUMBAR SPINE
 - CHEST
 - SHOULDER
 - ELBOW
 - WRIST
 - HAND
 - ABDOMEN
 - PELVIS
 - KNEE
 - ANKLE
 - FOOT
 - OTHER _____

CTA

- BRAIN
- CAROTID
- THORACIC AORTA
- ABDOMINAL AORTA
- RENAL

ULTRASOUND

- OB COMPLETE <14 WKS >14 WKS
 - TRANSVAGINAL (If Necessary)
- PELVIS
 - TRANSVAGINAL (If Necessary)
- ABDOMINAL
- SCROTAL
- GALLBLADDER
- RENAL
- AORTA
- CAROTID
- THYROID
- VENOUS DOPPLER Upper Ext Lower Ext
- ARTERIAL DOPPLER Upper Ext Lower Ext
- OTHER _____

XRAY

- SKULL
- SINUSES
- CHEST
- HIP
- EXTREMITY _____
- CERVICAL SPINE
- THORACIC SPINE
- LUMBAR SPINE
- OTHER _____

BUN AND CREATININE LAB
IF MEDICALLY INDICATED

Left **Right** **Bilateral**

IV Contrast If Medically Necessary

REASON FOR EXAM _____

INSURANCE CARRIER FOR PATIENT _____

INSURANCE ID# _____ INSURANCE PHONE # _____

REFERRING PHYSICIAN (PRINT) _____ SIGNATURE OF PHYSICIAN _____

CONTACT NAME AT OFFICE _____ CONTACT PHONE # _____

OFFICE FAX # _____

YUKON MEDICAL IMAGING IS HAPPY TO OBTAIN AUTHORIZATION FROM THE INSURANCE COMPANY WHEN IT IS ALLOWED.
FOR YOUR CONVENIENCE, WE WILL ALSO CALL THE PATIENT AND SET UP THE APPOINTMENT DATE AND TIME.
PLEASE FAX A COPY OF THIS FORM ALONG WITH A COPY OF THE PATIENT'S INSURANCE CARD TO
405-350-6823 AND WE WILL HANDLE THE REST!