



7499 Old Hwy. 441 South, Lakemont, GA 30552  
 Phone: 706-782-0770 Fax: 706-782-1091

## PROCEDURE ORDER FORM

### PATIENT INSTRUCTIONS:

- Bring this form, completed and signed by your physician, drivers license and your insurance cards to Medica at Rabun Open MRI. Arriving for testing without this form or a pre-certification number may result in cancellation or delay of your test.
- Medica will assist you and your physician in verifying eligibility of your insurance plan but it is ultimately your responsibility to check to see about coverage.

Date Ordered: \_\_\_\_\_ Person who scheduled exam: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SSN #: \_\_\_\_\_ Insurance company: \_\_\_\_\_

HOME Phone#:( ) \_\_\_\_\_ CELL#: ( ) \_\_\_\_\_ WORK#:( ) \_\_\_\_\_

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_ Patients Weight: \_\_\_\_\_

### PROCEDURE ORDERED (We will pre-certify most insurance plans):

<input type="checkbox"/> MRI Cervical Spine	<input type="checkbox"/> MRI Shoulder R L
<input type="checkbox"/> MRI Thoracic Spine wo W&W/O contrast	<input type="checkbox"/> MRI Knee R L
<input type="checkbox"/> MRI Lumbar Spine wo W&W/O contrast	<input type="checkbox"/> MRI Hip R L
<input type="checkbox"/> MRI Brain wo W&W/O contrast	<input type="checkbox"/> MRI Abdomen
<input type="checkbox"/> MRA : <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Both	<input type="checkbox"/> MRI Pelvis
	<input type="checkbox"/> Other _____
<b>Prior surgery</b> on exam ordered today? Yes: <input type="radio"/> No: <input type="radio"/> <b>Prior studies</b> of today's exam?: CT,US,XRAY Yes: <input type="radio"/> No: <input type="radio"/>	
Circle on this line whether exam is: <b>No Contrast</b> <b>W&amp;W/O Contrast</b>	

**Diagnosis or reason for exam. Please include (ICD-9):** \_\_\_\_\_

### PATIENT HISTORY (preliminary MRI screening): Does patient have or ever had:

Yes: <input type="radio"/> No: <input type="radio"/> <b>Metal in Eyes?</b>	Yes: <input type="radio"/> No: <input type="radio"/> <b>Pacemaker?</b>
Yes: <input type="radio"/> No: <input type="radio"/> <b>If yes, was it removed?</b>	Yes: <input type="radio"/> No: <input type="radio"/> <b>Pregnant?</b>
Yes: <input type="radio"/> No: <input type="radio"/> <b>Claustrophobic?</b>	<b>Please check your instructions below:</b>
Yes: <input type="radio"/> No: <input type="radio"/> <b>Ear or eye implants?</b>	<input type="checkbox"/> CD <input type="checkbox"/> FILMS
Yes: <input type="radio"/> No: <input type="radio"/> <b>Brain aneurysm clip?</b>	<input type="checkbox"/> Phone Preliminary Report# _____
Yes: <input type="radio"/> No: <input type="radio"/> <b>Body piercing?</b>	<input type="checkbox"/> Fax Preliminary Report # _____
Yes: <input type="radio"/> No: <input type="radio"/> <b>Surgery</b> in the past 6 weeks? If yes, what type?	

**Physician Name (please print)** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*(Based upon the patient's history, exam and diagnosis, I have requested the test(s). I hereby certify that the tests are medically necessary).*

(Directions on Back)