



## REQUIRED FOR AUTHORIZATION

Patient \_\_\_\_\_ DOI \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ PI   
 Insurance \_\_\_\_\_ WC   
 Policy & Group # \_\_\_\_\_ CASH   
 Payor/Attorney \_\_\_\_\_

## REFERRING PHYSICIAN

Name \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Fax \_\_\_\_\_  
 Address \_\_\_\_\_

CLAUSTROPHOBIC

Patient's Next Dr. Appt

## PHYSICIAN SIGNATURE

Date \_\_\_\_\_

# MRI

## MUSCULOSKELETAL

	Multi - Position	Without Contrast	L	R
TMJ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clavical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SC Joint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scapula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Humerous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radius/Ulna	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Femur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tibia/Fibula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ankle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## SPINE

	Multi - Position	Without Contrast
Cervical	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar	<input type="checkbox"/>	<input type="checkbox"/>
Sacrum/Coccyx	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

## VASCULAR

	Without Contrast	L	R
COW	<input type="checkbox"/>		
Carotids	<input type="checkbox"/>		
Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic Aorta	<input type="checkbox"/>		
Abdominal Aorta	<input type="checkbox"/>		
Renal Vessels	<input type="checkbox"/>		
Liver/IVC/ Phasic	<input type="checkbox"/>		
Pelvis/Iliacs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AIBF Runoff	<input type="checkbox"/>		
Other	<input type="checkbox"/>		

## BODY

	Without Contrast
Soft Tissue Neck	<input type="checkbox"/>
Brachial Plexus	<input type="checkbox"/>
Chest	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>
MRCP	<input type="checkbox"/>
Pelvis	<input type="checkbox"/>
Prostate	<input type="checkbox"/>
Other	<input type="checkbox"/>

## BRAIN/HEAD

	Without Contrast
Brain	<input type="checkbox"/>
Brain TBI	<input type="checkbox"/>
Pituitary	<input type="checkbox"/>
IAC	<input type="checkbox"/>
Sinus	<input type="checkbox"/>
Orbits	<input type="checkbox"/>
Face	<input type="checkbox"/>
DTI/ Tractography	<input type="checkbox"/>
Other	<input type="checkbox"/>

## EMAIL

Email us at [referrals@nationsmri.com](mailto:referrals@nationsmri.com)  
 and our team will reach out to the  
 patient to schedule an appointment  
 at the nearest location.

## CALL

To speak to a member of our  
 team, call **888 811-1011**

## CONTACTS

Referrals: [referrals@nationsmri.com](mailto:referrals@nationsmri.com)

Billing & Records: [documents@nationsmri.com](mailto:documents@nationsmri.com)

### WOODLAND HILLS

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 Woodland Hills, CA 91364

### LOS ANGELES

3760 Santa Rosalia Drive  
 Los Angeles, CA 90008

### HUNTINGTON PARK

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 Huntington Park, CA 90255