



**Physicians Order/  
Scheduling Worksheet**

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Physician Ordering Test/Facility: \_\_\_\_\_

MRI Scan of: \_\_\_\_\_

Diagnosis / Symptoms (include duration & intensity):  
\_\_\_\_\_  
\_\_\_\_\_

**Please call our office if the patient is positive for any of the following contraindications:**

Pacemaker, aneurism clips, heart or vascular surgery, or any other internal devices, implants or prosthetics? Y N

Is there a possibility of pregnancy? Y N

Does the patient have a possibility of metal in their eyes? Y N

**INSURANCE INFORMATION**

Health Plan: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

If Auto or Work Comp

Carrier: \_\_\_\_\_ Claim #: \_\_\_\_\_ DOI: \_\_\_\_\_

**INSTRUCTIONS**

- Patient already scheduled
- Call Patient to Schedule
- Date & Time \_\_\_\_\_
- Patient will call to schedule

Physicians Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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