OPEN MRI
LIBERAL DIAGNOSTIC

23 Professional Dr.

Exam Order Form

Please call to schedule:
Phone: *620-626-5412* **Fax:** *620-626-5420*

Patient Name: _____

Patient D.O.B: _____

Patient Insurance: _____

Date of Injury: _____

MRI of: _____

Diagnosis: _____

Date/Time Scheduled: _____

Claustrophobic: yes/no Pacemaker: yes/no Pregnant: yes/no

Hardware: yes/no What: _____
(surgical clips/total joints/aneurysm clips/metal in eyes/ F.B./ screws/plates/)
(if patient has heart stent, copy stent card, and fax to MRI with this sheet)

Physician's Signature: _____

Patient Consent:

My physician has referred me to Liberal Diagnostic for Open MRI (Magnetic Resonance Imaging), I have been informed that this exam has no inherent risks EXCEPT **for patients who have a cardiac pacemaker, surgical clips on the arteries, of the brain or metal fragments in the eyes.**

I have read and understand the above statements and consent to the MRI.

Patient's Signature: _____ Date: _____

Precert needed: YES/NO

Date/Time called: _____ Phone #: _____
Insurance Rep: _____
Benefits: _____