4800 S. Saginaw St. Suite 1650, Flint, MI 48507
Phone: (810) 275-9688 Fax: (810) 963-1900 www.iinn.com - imaging@iinn.com

X-Ray Order Form

Walk in or Call for an Appointment

Patient Name: ______________________ **Date of Birth:** ____/____/____ **Sex:** ________

Address: ______________________ **City:** ____________ **Zip:** ________

Phone: ______________________ **Insurance & ID Number:** ______________________

Symptoms/Diagnosis/Pertinant History: ______________________

____

Spine

_____ Cervical Spine, AP & Lat
_____ Cervical, Flex & Ext
_____ Cervical Spine w/ Obliques
_____ Thoracic Spine
_____ Thoracolumbar Junction
_____ Lumbar Spine, AP & Lat
_____ Lumbar Spine, Flex & Ext
_____ Lumbar Spine W/ Obliques
_____ Sacrum & Ccccyx
_____ SI Joints (Right, Left, Both)
_____ Scoliosis

Upper Extremity

_____ Clavicle
_____ Shoulder
_____ Scapula
_____ Humerous
_____ Elbow
_____ Forearm
_____ Wrist (2v, 3v)
_____ Hand (2v, 3v)
_____ Sterno Clavicular Joints
_____ Fingers
_____ AC Joints

Lower Extremity

_____ Pelvis (AP, Judet, Inlet/outlet)
_____ Hip, Right
_____ Hip, Left
_____ Hip, Bilateral
_____ Femar
_____ Knee, Right
_____ Knee, Left (2v, 3v, 5v)
_____ Tibia & Fibula
_____ Ankle (2v, 3v)
_____ Foot (2v, 3v)
_____ Os Calcis (Heel)
_____ Toes

Thoracic

_____ Chest, PA & Lat
_____ Ribs, Unilateral
_____ Ribs, Bilateral
_____ Sternum

Head

_____ Nasal Bones
_____ Skull (AP & Lat, Complete)
_____ Sinuses
_____ Facial Bone
_____ Orbits
_____ Mandable
_____ Pre MRI eyes

Abdomen

_____ KUB
_____ Abdomen Upright
_____ Abdomen Series 3v
_____ Abdomen Flat & Upright
_____ Other

Physician Signature: ______________________ **Date of Order** ____/____/____

Phone Number: ______________________ **Fax Number:** ______________________

INSIGHT
IMAGING

4800 S. Saginaw St. Suite 1650, Flint, MI 48507
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MRI Referral Form

Patient Name: ______________________

DOB: ______________ Phone: ______________

Appointment Date: ______________ Time: ______________

Diagnosis/Signs/Symptoms (clinical data): ______________________

____

____

Referring Physician: ______________ Signature: ______________

Telephone Report to: ______________ Fax Report To: ______________

☐ CT Scan ☐ MRI X-Ray (Use Reverse Side)

Neurological

☐ Brain

I.A.C Pituitary Gland Orbits

☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Sacrum/Coccyx

Body

☐ Abdomen ☐ MRCP ☐ Pelvis ☐ SI Joint ☐ Neck/Soft Tissue

MSK: ______________ ☐ Right ☐ Left ☐ Bilateral

MRA: ______________ ☐ Arterial ☐ Venous

Other: ______________

☐ With Only ☐ Without Contrast ☐ With & Without Contrast

Open MRI Yes No