CARDIOVASCULAR MRI
OUTPATIENT PROCEDURE REQUEST

BOSHELL BUILDING
SUITE 101
1808 7TH AVE SOUTH
PHONE (205)934-9906 FAX (205)975-1952

Patient Name: ______________________ **DOB:** __________ **Sex:** ______

Phone#: ( ) ______________________ **MRN:** ______________________

Attending MD: ______________________ **Referring MD:** ______________________

DIAGNOSIS

REASON STUDY IS REQUESTED
(Please be very specific. Must include enough clinical information to justify use of cardiac magnetic resonance imaging. Include any pertinent previous diagnostic testing results.)

CARDIAC

- ☐ VENTRICULAR FUNCTION
- ☐ VALVE ASSESSMENT
- ☐ R/O MASS
- ☐ CONGENITAL
- ☐ PERICARDIAL DISEASE
- ☐ OTHER ______________________

VASCULAR

- ☐ THORACIC AORTA
- ☐ ABDOMINAL AORTA
- ☐ RENAL ARTERIES
- ☐ CAROTID/ VERTEBRALS
- ☐ ILIOFEMORALS
- ☐ OTHER ______________________

DOES THE PATIENT HAVE ANY OF THE FOLLOWING?

- Y N CARDIAC PACEMAKER, ICD, OR PACING WIRES
- Y N ANEURYSM CLIPS
- Y N METALLIC FOREIGN BODY
- Y N WEIGHT ABOVE 250 LBS.

If yes please notify a technologist at CVMRI, 934-9906. Failure to identify the above can be potentially life threatening for the patient.

Insurance Info:

Primary Carrier	______________	Secondary Carrier	______________
Policy Holder:	______________	Policy Holder:	______________
Policy #	______________	Policy #	______________
Group #	______________	Group #	______________

***Precertification required?: Yes ______ No______ Authorization #: ______________

Precertification performed by: ______________________ (Name of person at insurance company)

***Note: Many insurance companies require precertification for cardiac MRI procedures. If given 48 hours notice, the CVMRI staff will obtain these precertifications if additional clinical information is provided. If study needs to be performed same or next day, please call the number on the back of the patient's insurance card and obtain authorization number before scheduling study.

Ordered by: ______________________ Extension: ______________________

Date Scheduled: ______________________ Time: ______________________

Does patient have a clinic visit scheduled on day of exam? Time______________

To order study:

1. Complete request form. *
2. Call 934-9906 to schedule date & time. Give patient directions to facility.
3. Fax request form to CVMRI at (205) 975 1952.

* A MRI technologist will be glad to complete this form for you over the telephone. However, the caller must be able to provide all information requested.