

MRI Referral Form



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Office: 541-570-1728
www.northwestmri.com

Patient: _____ Date of Birth: _____

Cell Phone: _____ Home Phone: _____

MRI: _____

Diagnosis: _____

ICD.9

Ordering Physician: _____

Ordering Provider signature: _____

Physician Phone: _____ Fax: _____

Physician e-mail (For secure online link to PACS): _____

Notes: _____

For IV Contrast Studies:

Table with 3 columns: Condition, YES, NO. Rows include Diabetic, Allergies, Pregnant, Breastfeeding.

Please Identify All Contraindications:

Table with 3 columns: Contraindication, YES, NO. Rows include Claustrophobic, Pacemaker, Artificial Valves, Aneurysm Clips, Nerostimulator, Cochlear Implants, Surgically Implanted Metal, Worked w/ grinders, welding.

Our mission is to provide high quality, accessible, and affordable MRI services for economical minded consumers in a fast, friendly, and professional manner.