750 94th Avenue North, Suite 206
St. Petersburg, Florida 33702
www.saintpetemri.com

Saint Pete

MRI

Easy Authorization Form

PRESCRIPTION
Fax: 727.563.0614

Patient Name: _____

Date of Birth: _____

Phone: _____

Alt. Phone: _____

☐ Would you like us to obtain authorization?

PLEASE SEND PERTINENT OFFICE NOTES WITH THIS FORM

SS#: _____

Today's Date: _____

Authorization #: _____

Insurance Provider: _____

Member #: _____

Symptoms / Diagnosis:

_____

_____

_____

_____

_____

_____

_____

Physician's Printed Name

Physician's Signature / Date

YOUR APPOINTMENT IS:

Month: _____ **Year:** _____

Day: _____ **Time:** _____

☐ MRI ☐ MRA ☐ With IV Contrast ☐ W/O

		L	R	BiL
❑ Brain	❑ Hips	❑	❑	❑
❑ DTI/SWI	❑ Shoulder	❑	❑	❑
❑ IAC's	❑ Hand	❑	❑	❑
❑ Pituitary	❑ Wrist	❑	❑	❑
❑ Orbits	❑ Elbow	❑	❑	❑
❑ Cervical	❑ Knee	❑	❑	❑
❑ Neck (Soft Tissue)	❑ Ankle	❑	❑	❑
❑ Thoracic	❑ Foot	❑	❑	❑
❑ Lumbar	❑ TMJ	❑	❑	❑
❑ Chest	❑ Breast	❑	❑	❑
❑ Abdomen				
❑ Pelvis	❑ Other: _____			

Ultrasound

❑ Abdomen	❑ Thyroid
❑ RUQ	❑ Breast ❑ L ❑ R
❑ Kidneys	Specify Region _____
❑ Aorta	❑ Vascular
❑ OB	❑ L ❑ R ❑ Art. ❑ Leg ❑ Arm
❑ Pelvis	❑ L ❑ R ❑ Ven. ❑ Leg ❑ Arm
❑ Transvaginal Pelvic US	❑ Superficial for Lump
❑ Carotid	Specify Body Area
❑ Scrotum	❑ Other: _____

❑ Echocardiogram

☐ CT ☐ CTA IV Contrast ☐ With ☐ W/O

❑ Brain	❑ Upper Ext.: _____
❑ IAC's	❑ L ❑ R (Specify Area)
❑ Orbits	❑ Lower Ext.: _____
❑ Chest	❑ L ❑ R
❑ High Res. Chest	❑ Cervical (Specify Area)
❑ Abdomen	❑ Thoracic
❑ Pelvis	❑ Lumbar
❑ CT Enterography	❑ Neck - Soft Tissue
❑ Urogram	❑ Other: _____
❑ Sinus	
❑ Stealth Sinus	

X-Ray - Specify # of views

		L	R	BiL
❑ Chest _____	❑ Ribs	❑	❑	❑
❑ Sinus _____	❑ Shoulder	❑	❑	❑
❑ Abdomen _____	❑ Elbow	❑	❑	❑
❑ Cervical _____	❑ Wrist	❑	❑	❑
❑ Thoracic _____	❑ Hand	❑	❑	❑
❑ Lumbar _____	❑ Hip	❑	❑	❑
	❑ Knee	❑	❑	❑
	❑ Ankle	❑	❑	❑
Other: _____	❑ Foot	❑	❑	❑

750 94th Avenue North, Suite 206
St. Petersburg, Florida 33702
www.saintpetemri.com

Saint Pete

MRI

Easy Authorization Form

PRESCRIPTION
Fax: 727.563.0614

Patient Name: _____

Date of Birth: _____

Phone: _____

Alt. Phone: _____

☐ Would you like us to obtain authorization?

PLEASE SEND PERTINENT OFFICE NOTES WITH THIS FORM

SS#: _____

Today's Date: _____

Authorization #: _____

Insurance Provider: _____

Member #: _____

Symptoms / Diagnosis:

_____

_____

_____

_____

_____

_____

_____
Physician's Printed Name

_____
Physician's Signature / Date

YOUR APPOINTMENT IS:

Month: _____ **Year:** _____

Day: _____ **Time:** _____

☐ MRI ☐ MRA ☐ With IV Contrast ☐ W/O

		L	R	BiL
❑ Brain	❑ Hips	❑	❑	❑
❑ DTI/SWI	❑ Shoulder	❑	❑	❑
❑ IAC's	❑ Hand	❑	❑	❑
❑ Pituitary	❑ Wrist	❑	❑	❑
❑ Orbits	❑ Elbow	❑	❑	❑
❑ Cervical	❑ Knee	❑	❑	❑
❑ Neck (Soft Tissue)	❑ Ankle	❑	❑	❑
❑ Thoracic	❑ Foot	❑	❑	❑
❑ Lumbar	❑ TMJ	❑	❑	❑
❑ Chest	❑ Breast	❑	❑	❑
❑ Abdomen				
❑ Pelvis	❑ Other: _____			

Ultrasound

❑ Abdomen	❑ Thyroid
❑ RUQ	❑ Breast ❑ L ❑ R
❑ Kidneys	Specify Region _____
❑ Aorta	❑ Vascular
❑ OB	❑ L ❑ R ❑ Art. ❑ Leg ❑ Arm
❑ Pelvis	❑ L ❑ R ❑ Ven. ❑ Leg ❑ Arm
❑ Transvaginal Pelvic US	❑ Superficial for Lump
❑ Carotid	Specify Body Area
❑ Scrotum	❑ Other: _____

❑ Echocardiogram

☐ CT ☐ CTA IV Contrast ☐ With ☐ W/O

❑ Brain	❑ Upper Ext.: _____
❑ IAC's	❑ L ❑ R (Specify Area)
❑ Orbits	❑ Lower Ext.: _____
❑ Chest	❑ L ❑ R
❑ High Res. Chest	❑ Cervical (Specify Area)
❑ Abdomen	❑ Thoracic
❑ Pelvis	❑ Lumbar
❑ CT Enterography	❑ Neck - Soft Tissue
❑ Urogram	❑ Other: _____
❑ Sinus	
❑ Stealth Sinus	

X-Ray - Specify # of views

		L	R	BiL
❑ Chest _____	❑ Ribs	❑	❑	❑
❑ Sinus _____	❑ Shoulder	❑	❑	❑
❑ Abdomen _____	❑ Elbow	❑	❑	❑
❑ Cervical _____	❑ Wrist	❑	❑	❑
❑ Thoracic _____	❑ Hand	❑	❑	❑
❑ Lumbar _____	❑ Hip	❑	❑	❑
	❑ Knee	❑	❑	❑
	❑ Ankle	❑	❑	❑
Other: _____	❑ Foot	❑	❑	❑