MRI – Physician REFERRAL Order SHEET

Patient Name:________________________ DOB:___________ Requested Location:____________________

Procedures	ICD-10 Diagnosis (See ICD Ticket & Office Notes)
☐ BRAIN ☐ MRI w/o ☐ MRI wi/wo	☐ Vascular IIA w/o Intractable G43.011/G43.919 ☐ Headache NOS G44.319 ☐ Trig Neuralgia/Atyp Face Pain G50.0 ☐ Dizziness/Vertigo R42 ☐ Ataxia/Abnl gait/Incoor R26.0
☐ CERVICAL ☐ MRI w/o ☐ MRI wi/wo	☐ Cervalgia/Radic/B.Plexitis M54.2/M43.12/G54.0 ☐ Numb, Ting, Paresthesia R20.0/R20.2 ☐ Muscle/Liga/or Fase unsp d/o M62.9 ☐ Limb Pain/Periph Neuropathy M79.609/G60.8 ☐ Cervical Strain/DDD S13.4xxA/M50.30 ☐ Spondylosis without/with M47.812/M47.12 ☐ Spurling's +R +L/ Tend/Decr ROM/Spasm ☐ Other M62.838
☐ THORACIC ☐ MRI w/o ☐ MRI wi/wo	☐ Thoracic/Radiculopathy M54.6/M54.14 ☐ Numb, Ting, Paresthesia R20.0/R20.2 ☐ Muscle/Liga/or Fase unsp d/o M62.9 ☐ Thoracic Strain/DDD S23.3xxA/M51.34 ☐ Spondylosis without/with Tend/Decr ROM/Spasm M47.812/M47.14 ☐ (Spasm) M62.830
☐ LUMBAR ☐ MRI w/o ☐ MRI wi/wo	☐ Lumbago/Sciatical/LS Pain M54.5/M54.30/M43.27 ☐ Numb, Ting, Paresthesia R20.0/R20.2 ☐ Muscle/Liga/or Fase unsp d/o M62.9 ☐ Limb Pain/Periph Neuropathy M79.609/G60.8 ☐ Lumbar Strain/DDD S33.5xxA/M51.36 ☐ Spondylosis without/with M47.817/M47.16 ☐ **L-Post.Lam.Syndrome M96.1 ☐ SLR +R +L/ Tend/Decr ROM/Spasm ☐ Other (Spasm) M62.830
☐ Shoulder/Hip/Knee/Other MRI R/L wi/wo	☐ Shoulder/Hip/Knee M25.519/M25.559/M25.569 ☐ Dec ROM, Swelling Surgery, Fall Popping

I am the physician who ordered the above studies and certifies the medical necessity of this order.

Physician Signature ____________________________________ Date:________________
MD/NP/PA

PLEASE PROVIDE THE PATIENT WITH A COPY OF BOTH FILMS/CD AND REPORT. By signing my name below, I agree that this referral form was had delivered to me on ________________. I understand I have up to 30 days to have this done. I will hand carry evidence of this to my next office visit. I also understand that if I fail to comply, I may not receive any schedule or control substances as part of my treatment at the next office visit and I may even be release as a patient from The HEAG Pain Management Center.

Patient Signature: ____

Please fax copy of report to: 1-888-625-0309

2609 N Duke Street, Suite 303-B ~ Durham, NC 27704 ~ Tel. 919-220-0107
1305 W Wendover Avenue, Suite A ~ Greensboro, NC 27408 ~ Tel. 336-282-0132
2245 H Stantonsburg Road ~ Greenville, NC 27834 ~ Tel. 252-364-2830
106 Baker Drive ~ Archdale, NC 27263 ~ Tel. 336-434-3435
203 Pomona Drive ~ Greensboro, NC 27407 ~ Tel. 336-282-0132