# Cayman Medical Ltd.

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## MRI Request Form

| | | | |
|---|---|---|---|
| **Name** - Last: | First: | Middle: | Date of Birth: DD/MM/YYYY |
| **Phone** - Home: | Cell: | Sex: Select | Height: Ft/In Weight: Lbs |
| Insurance Name: | Member ID#: | Group ID#: | Plan Name: |
| Policy Owner: | | | |

| | | | |
|---|---|---|---|
| Metal or electronic Implants Y/N<br>Pacemaker/ Defibrillator Y/N<br>Aneurysm Clips Y/N | Heart, Kidney or Liver disease Y/N<br>H/O Stroke Y/N<br>Able to stand for 15 mins? Y/N | Diabetic Y/N<br>HTN Y/N<br>Cancer Y/N | Pregnant or breastfeeding Y/N<br>Allergies: |

| | |
|---|---|
| Prior Imaging Y/N (Location and date): | Desired appointment date:<br>*Standard / ASAP / Urgent* |
| Indication/Diagnosis (+ ICD-10 Code): | |
| Special notes: | |

**Requested Procedures** (please check available studies in the white fields)

| Description | Contrast? | | Weight-Bearing | Dynamic | In-Motion |
|---|---|---|---|---|---|
| | Without | With & WO | | | |
| MRI Brain | ☐ | ☐ | | | |
| MRI Sella/Pituitary | ☐ | ☐ | | | |
| MRI Internal Auditory Canal (IAC)/Cerebellopontine Angle | ☐ | ☐ | | | |
| MRI Orbit/Face | ☐ | ☐ | | | |
| MRI Temporomandibular Joint(s) | ☐ | ☐ | | ☐ | ☐ |
| MRI Neck | ☐ | ☐ | | | |
| MRI Cervical Spine | ☐ | ☐ | ☐ | ☐ | ☐ |
| MRI Thoracic Spine | ☐ | ☐ | | | |
| MRI Lumbar Spine | ☐ | ☐ | ☐ | | |
| MRI Upper Extremity Non-Joint (please specify: _____) | ☐ | ☐ | | | |
| MRI Upper Extremity Joint (please specify: _____) | ☐ | ☐ | ☐ | ☐ | ☐ |
| MRI Lower Extremity Non-Joint (please specify: _____) | ☐ | ☐ | | | |
| MRI Lower Extremity Joint (please specify: _____) | ☐ | ☐ | ☐ | ☐ | ☐ |

Practice Name_____ Practice Phone_____Practice Fax_____

Physician Name_____ Physician Signature_____ Date DD/MM/YYYY

**We encourage referring doctors to use our doctor portal, which allows instant orders, instant notifications and instant access to reports and imaging:**

# https://portal.medical.ky