BERMUDA HEALTHCARE SERVICES

19 THE LANE
PAGET PG 05
BERMUDA

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MRI REFERRAL

PATIENT NAME _____ DATE _____

PATIENT ADDRESS _____

DOB (DD/MM/YY) _____ M-F PHONE (C)_____ (W)_____ (H)_____

EMAIL _____

APPT. DATE: _____ TIME: _____ LAHEY CLINIC # _____

INSURANCE COMPANY : _____ POLICY #: _____ CERTIFICATE: _____

HEAD

- ☐ BRAIN
- ☐ SELLA
- ☐ ORBITS
- ☐ IAMS
- ☐ OTHER _____

_____

_____

MRA

- ☐ HEAD
- ☐ NECK
- ☐ CHEST
- ☐ MEDIASTINUM

SPINE

- ☐ CERVICAL
- ☐ THORACIC
- ☐ LUMBAR
- ☐ SACRUM
- ☐ SOFT TISSUE NECK
- ☐ OTHER _____

ABDOMEN

- ☐ LIVER
- ☐ PANCREAS
- ☐ KIDNEY
- ☐ ADRENALS
- ☐ AORTA
- ☐ OTHER _____

UPPER EXTREMITY

- ☐ SHOULDER R or L
- ☐ HUMERUS R or L
- ☐ ELBOW R or L
- ☐ FOREARM R or L
- ☐ WRIST R or L
- ☐ HAND R or L
- ☐ FINGER R or L
- ☐ OTHER _____

_____

_____

_____

_____

LOWER EXTREMITY

- ☐ HIP R or L
- ☐ FEMUR R or L
- ☐ KNEE R or L
- ☐ TIB/FIB R or L
- ☐ ANKLE R or L
- ☐ FOOT R or L
- ☐ TOE R or L
- ☐ FEMALE PELVIS
- ☐ ORTHO PELVIS
- ☐ PROSTATE / MALE PELVIS
- ☐ RUN OFF LEGS
- ☐ OTHER _____

_____

SERUM CREATININE LAB IS REQUIRED ON ALL PATIENTS NEEDING CONTRAST

CREATININE_____ DATE_____

IS THIS PATIENT ON DIALYSIS? YES ☐ NO ☐

IF YES, PATIENT SHOULD HAVE DIALYSIS WITHIN 24 HRS AFTER INFUSION OF CONTRAST.

SYMPTOMS/REASON(S) FOR MRI _____

_____

_____

REFERRING DR._____ PHONE (O)_____ (C)_____

SIGNATURE _____ FAX_____

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