

Patient

Name _____

DOB _____ Sex _____

Phone # _____

Cell # _____

Name of Insurance _____

Claim # _____

Referring Physician

Name _____

Fax # _____

Phone # _____

Address _____

Clinical Impression _____

Signature _____ Date _____

Nassau Open MRI

(c/o Queens Radiology)

23-08 30th Avenue · Astoria, New York 11102

tel: 718.726.2000 fax: 718.728.2724

MRI

- ___ Brain Shoulder L R
- ___ Chest Elbow L R
- ___ Abdomen Wrist L R
- ___ Pelvis Hand L R
- ___ TMJ Hip L R
- ___ C-Spine Knee L R
- ___ T-Spine Ankle L R
- ___ L-Spine Foot L R

Other _____

X-Ray

- ___ Skull Shoulder L R
- ___ Chest (AP & Lat) Ribs L R
- ___ Elbow Wrist L R
- ___ C-Spine Hand L R
- ___ T-Spine Hip L R
- ___ L-Spine Knee L R
- ___ Pelvis Ankle L R
- ___ Sacroliac Joints Foot L R

Other _____

Please Bring Proper Identification

Instructions:

- Please wear comfortable clothing.
- No Jewelry
- No Metal of ANY kind
- No Pacemakers
- No Zippers
- No Underwires
- No Clips or Buckles
- No Belts
- No Hair clips/pins
- No Earrings/Piercings

If you are or may be pregnant, please advise our staff immediately.

