

MRI Outpatient Order Form

Phone: 507.386.6750

Fax: 507.388.1457



1431 Premier Drive | Mankato, MN 56001

Complete and fax this order form.

Appointment Information

Appointment Date

Appointment Time

Scheduling Information

Patient Name

Date of Birth/Male or Female

Street Address, City, State, Zip Code

Social Security #

Home Telephone

Work Telephone

Cell Phone

Type of scan/Area of the body

Contrast Y/N (if contrast is needed, please notify MRI at time of scheduling)

If yes, please provide creatinine value within 30 days for all patients with renal insufficiency and those age 65 and older.

Symptoms/History/Diagnosis

Injury? Y/N Date: _____

Pertinent Previous Studies: (X-rays are required for all spine MRI's)

Study Type	Body Part	Date	Where
X-Rays			
CT			
Ultrasound			
Nuclear Medicine			
MRI			
Other			

Referring Physician

Clinic/Office

Telephone Number

Contact Person

Scheduler/Telephone Number

Fax Number

Insurance Information (Copy of all insurance card(s) (front and back) must be attached)

Preauthorization Needed Yes No

Insurance Carrier/Address

Group #

Subscriber's Name

Policy #

Motor Vehicle

Work-Related - Date of Injury _____

Employer _____ Telephone No. _____