



at the Flint NeuroScience Centre
 G-3231 Beecher Road, Flint, MI 48532
 810-230-2411
 810-230-2515 Fax

Patient Requisition Form

****PATIENT- PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT.
 THE TEST CANNOT BE PERFORMED WITHOUT THIS FORM.**

To Be Completed By REFERRING PHYSICIAN OFFICE

Exam Requested: _____ Date of Order: _____

Diagnosis/Clinical Indications: _____

Ordering Physician: _____ Called in by: _____

Insurance precertification/verification #: _____

For Breast MRI/Biopsy - Please send all recent reports of patients mammogram, ultrasound and/or biopsy.

Date of last menstrual cycle? _____

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SS#: _____ Height: _____ Weight: _____

Primary Insurance _____

Cardholder's Name: _____ Cardholder's DOB: _____

Contract#: _____ Group#: _____ Service Code: _____

Employer Name: _____

Employer Address: _____ Employer Phone: _____

Secondary Insurance: _____

Cardholder's Name: _____ Cardholder's DOB: _____

Contract#: _____ Group#: _____ Service Code: _____

Employer Name: _____

Employer Address: _____ Employer Phone: _____

MRI Safety Screening Check all that apply to you:

<input type="checkbox"/> Aneurysm Clips	<input type="checkbox"/> Decreased Kidney Function
<input type="checkbox"/> Brain Surgery	<input type="checkbox"/> IUD (Copper Contraceptive Device)
<input type="checkbox"/> Cancer, history of	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Claustrophobia	<input type="checkbox"/> Pregnant or Breast Feeding
<input type="checkbox"/> Cochlear, Otologic, or other ear implant	<input type="checkbox"/> Surgical implants

Have you ever worked around metal shavings/metal grinding/ welding, or ever had metal washed/ removed from your eyes? Yes No