SIOUX FALLS
OPEN-UPRIGHT MRI, LLC
A NATURAL *SHIFT* IN IMAGING

6001 S. Sharon Ave., Ste. #7
Sioux Falls, SD 57108
Call: (605)275-5743
Fax: (605)271-2235
www.sfOpenUprightMRI.com

PHYSICIANS ***MRI REFERRAL ORDER***

Please fax order to: ***(605)271-2235***

PATIENT INFORMATION

Name:_____ DOB:_____/_____/_____

Insurance:_____

If MVA or Work Comp. - **Name of Coverage:**_____ Claim #:_____

Address:_____City/St./Zip_____ Phone: (_____) _____-_____

Appt. Time & Date:_____ Pt. Cell or Home #:(_____) _____-_____

EXAM INFORMATION

Type of MRI Exam:_____ *If Extremity* ☐ Right ☐ Left ☐ Bilateral

If **Cervical** *or* **Lumbar** *exam, please select additional views if needed:*

☐ **Flexion** ☐ **Extension** ☐ **Standing** ☐ **Recumbent**

Please provide a summary of patient symptoms:_____

_____

_____

_____

_____

Please provide Sioux Falls Open Upright MRI with any **history on the area being scanned** by faxing it with the written order to (605)271-2235. **Previous history includes:**

☐ X-Ray ☐ MRI ☐ CT ☐ Surgery ☐ Cancer

Does the patient have or has the patient had:

☐ Allergies to contrast agents ☐ Renal Failure/Dialysis - *If yes, have labs been drawn?*

PHYSICIAN INFORMATION

Ordering Physician:_____ Clinic:_____

Address:_____ City/St./Zip_____

Office Number: (_____) _____-_____ Fax Number: (_____) _____-_____ Date: _____/_____/_____

_____

Signature of Ordering Physician

This form available at: www.SFopenUprightMRI.com