MAX MRI RADIOLOGY
A MEDICAL GROUP, INC.

Fax – 888 740-4446
Scheduling – 800 851-4150

Patient Name:_____

Address:_____

Home Phone:_____ Cell Phone:_____

DOB:_____ SS#:_____

Referring Physician:_____ City:_____

Phone:_____ Fax:_____

Physician's Signature:_____ Diagnosis: _____

☐ STAT Wet Read ☐ IPACS/On-line ☐ CD ☐ Patient to Hand Carry

Images available on IPACs, check CD if needed

MRI REQUEST: ☐ with contrast ☐ without contrast

☐ Cervical Spine ☐ Thoracic Spine ☐ Abdomen ☐ Lumbar Spine

☐ Chest ☐ Pelvis ☐ Elbow Right☐ Left☐ ☐ Hand Right☐ Left☐

☐ Hip Right☐ Left☐ ☐ Knee Right☐ Left☐ ☐ Ankle Right☐ Left☐ ☐ Foot Right☐ Left☐

☐ TMJ Right☐ Left☐ ☐ Wrist Right☐ Left☐ ☐ Shoulder Right☐ Left☐ ☐ Other:_____

☐ Brain

Area of brain: _____

☐ Brain DTI/TBI (3T San Diego 1.5T Chula Vista)

☐ MRI Arthrogram Request – Please specify joint:_____

☐ Special Request – Please specify body part: _____

Billing Information

☐ PI Lien ☐ Private Insurance ☐ Work Comp ☐ Other (specify):_____

Insurance:_____

Insurance Address:_____

Insurance Phone:_____ Date of Injury: _____

Claim #:_____ Adjuster:_____

Attorney:_____ Contact:_____

Attorney Address:_____

Phone:_____ Fax:_____

17530 Ventura Blvd #106
Encino, 91316

7711 Amigos Ave #C
Downey, 90241

865 3rd Ave #121
Chula Vista, 91911

9380 Waples St #104
San Diego, 92121