Clarus Imaging, LLC

MRI REFERRAL / ORDER SLIP

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Phone 812-551-1994 · **Fax 812-551-1818**
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PATIENT INFORMATION

PATIENT NAME _____ **TODAY'S DATE** _____ **DATE OF BIRTH** _____

PATIENT PHONE _____ **ALTERNATE PHONE** _____ **BEST TIME TO CALL** _____

Payment choice: ☐ Self-pay ☐ Use insurance

INSURANCE INFORMATION, IF USING INSURANCE _____ **MEMBER ID** _____ **PRIOR AUTHORIZATION, IF REQUIRED** _____

MRI ORDER — NON-CONTRAST MRI ONLY

Check each ordered study. Specify the exact body part and right or left laterality when applicable.

ORDER	STUDY	CPT	BODY PART / LATERALITY
☐	**Brain / Head**	**70551**	Body part: _____
☐	**Cervical Spine**	**72141**	Notes: _____
☐	**Thoracic Spine**	**72146**	Notes: _____
☐	**Lumbar Spine**	**72148**	Notes: _____
☐	**Pectoral & Clavicle**	**71550**	Body part: _____ R ☐ L ☐
☐	**Upper Extremity Non-Joint** (Hand, Forearm, Humerus, Scapula)	**73218**	Body part: _____ R ☐ L ☐
☐	**Upper Extremity Joint** (Shoulder, Wrist, Elbow)	**73221**	Body part: _____ R ☐ L ☐
☐	**Lower Extremity Non-Joint** (Foot, Femur, Tibia / Fibula)	**73718**	Body part: _____ R ☐ L ☐
☐	**Lower Extremity Joint** (Hip, Knee, Ankle)	**73721**	Body part: _____ R ☐ L ☐
☐	**Pelvis / Sacrum-Coccyx / SI Joints**	**72195**	Body part: _____

DIAGNOSIS / CLINICAL INDICATION

DIAGNOSIS AND RELEVANT SYMPTOMS / HISTORY

ORDERING PROVIDER

ORDERING PROVIDER NAME _____ **NPI** _____ **CALLBACK PHONE** _____ **PROVIDER FAX FOR REPORT DELIVERY** _____

ORDERING PROVIDER SIGNATURE _____ **DATE** _____

Fax completed order to 812-551-1818

Questions: 812-551-1994 · info@clarusimaging.com