

<input type="checkbox"/> Open MRI P 760-776-8001 F 760-776-9636	<input type="checkbox"/> Palm Desert P 760-674-8800 F 760-674-8646	<input type="checkbox"/> Palm Springs P 760-322-3036 F 760-322-3037	<input type="checkbox"/> La Quinta P 760-777-4646 F 760-777-4622
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**APPOINTMENT INFO:**

Date: \_\_\_\_\_ Time: \_\_\_\_\_

**TODAY'S DATE:**

\_\_\_\_\_

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Clinical History/Reason for Exam: \_\_\_\_\_

Insurance Information: \_\_\_\_\_ Patient's Phone: \_\_\_\_\_

Referring Physician (Print): \_\_\_\_\_ Physician Signature: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

 Patient to bring images to Doctor  **STAT**

MR	CT	ULTRASOUND	X-RAY
<b>MRI</b> <input type="checkbox"/> With & Without Contrast <input type="checkbox"/> With Contrast <input type="checkbox"/> Without Contrast  <b>MRI Angiography</b> <input type="checkbox"/> With & Without Contrast <input type="checkbox"/> With Contrast <input type="checkbox"/> Without Contrast <input type="checkbox"/> Brain - COW <input type="checkbox"/> Neck - Carotids <input type="checkbox"/> Other: _____  <b>MR Arthrography</b> ___Left ___Right ___Shoulder ___Elbow ___Wrist ___Hip ___Knee ___Ankle	<b>Diagnostic CT</b> <input type="checkbox"/> With & Without Contrast <input type="checkbox"/> With Contrast <input type="checkbox"/> Without Contrast  <b>CTA</b> <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Extremity: ___Upper ___Lower <input type="checkbox"/> Chest <input type="checkbox"/> Aorta & Runoff Vessel <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvic <input type="checkbox"/> Other: _____  <b>CT Arthrography</b> ___Left ___Right ___Shoulder ___Elbow ___Wrist ___Hip ___Knee ___Ankle  <b>CT Myelography</b> ___Left ___Right ___Shoulder ___Elbow ___Wrist ___Hip ___Knee ___Ankle	<input type="checkbox"/> Abdomen: _____ <input type="checkbox"/> Abdomen Limited ___Liver ___Gallbladder ___Right Upper Quadrant <input type="checkbox"/> Renal: _____ ___w/Bladder <input type="checkbox"/> Bladder: _____ <input type="checkbox"/> Aorta/Retroperitoneal: _____ <input type="checkbox"/> Pelvic Transabdominal <input type="checkbox"/> Pelvic Transvaginal <input type="checkbox"/> Scrotum ___w/Doppler <input type="checkbox"/> Thyroid: _____ <input type="checkbox"/> Venous Doppler (Duplex): _____ <input type="checkbox"/> Carotid Doppler (Duplex): _____ <input type="checkbox"/> Arterial Doppler (Duplex): _____ ___ABI (Anchial Brachial Index) <input type="checkbox"/> Extremity (Non-Vasular) <input type="checkbox"/> Other: _____	<input type="checkbox"/> Head: ___Skull ___Orbits ___Sinuses <input type="checkbox"/> Spine: ___Cervical ___Thoracic ___Lumbar <input type="checkbox"/> Chest: ___PA ___PA/LAT <input type="checkbox"/> Ribs: ___Unilateral ___Bilateral ___w/PA Chest <input type="checkbox"/> Abdomen: ___KUB ___Two Views <input type="checkbox"/> Pelvis <input type="checkbox"/> Hips w/AP pelvis, bilateral ___Unilateral ___Left ___Right <input type="checkbox"/> Extremity: ___Left ___Right ___Bilateral Specify body part: _____ <input type="checkbox"/> Other: _____

**CLINICAL INFORMATION NEEDED FOR INSURANCE PRE-AUTHORIZATION**

 Date of injury: \_\_\_\_\_  
 < 2 Weeks  2-4 Weeks  
 4-8 Weeks  > 2 Months

**Treatment History**
 Bed Rest  Phy. Therapy  OTC Meds  
 Oral Steroids  Rx Meds  Injections  
 Surgery: \_\_\_\_\_

Please bring this Imaging Request Form, I.D., and your insurance card with you on the day of your exam.

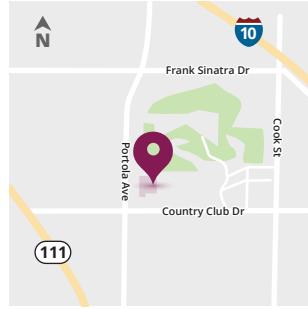


### OPEN MRI

72980 Fred Waring Dr.,  
Ste. A  
Palm Desert CA, 92260

**Phone: 760-776-8001**

**Fax: 760-776-9636**

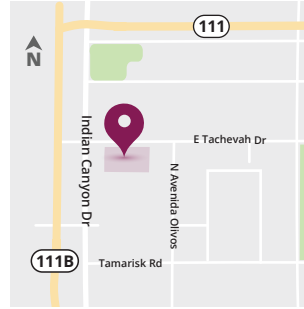


### PALM DESERT

74000 Country Club Dr.,  
Ste. E1/E2  
Palm Desert CA 92260

**Phone: 760-674-8800**

**Fax: 760-674-8646**

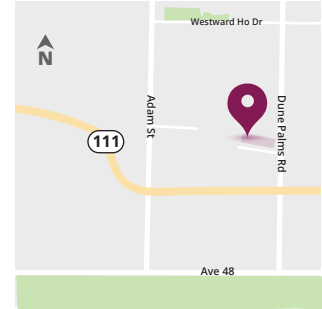


### PALM SPRINGS

1080 N. Indian Canyon,  
Ste. 104  
Palm Springs, CA 92262

**Phone: 760-322-3036**

**Fax: 760-322-3037**



### LA QUINTA

79440 Corporate Center Dr.,  
Ste. 118  
La Quinta, CA 92253

**Phone: 760-777-4646**

**Fax: 760-777-4622**

## PREPARATION INSTRUCTIONS

**MRI SCAN** Please inform us at the time of scheduling if you have any metal in your body or have had any surgeries to your eyes, ears, brain or heart. Remove any metal, jewelry or hair pins prior to your scan. Specific preparation information will be given when your appointment is scheduled. If you have any type of implant, please bring your safety card or obtain documentation that specifies the safety parameters of the implant.

**CT SCAN (Abdomen or Pelvis)** Contact the site for contrast instructions.

**AFTER THE EXAM** Your exam will be read by a board-certified, licensed physician with specialty training and certification in radiology. The results of your exam will be sent to your physician. You will receive your results from your physician.

**BILLING INFORMATION** If you have insurance coverage, we will submit a claim to your insurance company on your behalf. If you are a member of an HMO or managed care plan, please bring your referral form and any required copayment with you at the time of your visit. You are responsible for any outstanding or unpaid balance. If you have any questions, please call our Billing Department at (844) 866-2718, option 1.

### PLEASE BRING THE FOLLOWING ITEMS WITH YOU TO YOUR APPOINTMENT:

- This Imaging Request Form
- All prior related X-Rays / Scans
- Health Insurance Card & Picture I.D.
- Pre-Authorizations you may have received

CONNECT  
PATIENT PORTAL

[CONNECT.RADNET.COM/CVI](https://CONNECT.RADNET.COM/CVI)



CENTER	LOCATION	PHONE	FAX	MRI	Open MRI	CT	Ultrasound	DEXA	X-Ray
<input type="checkbox"/> Palm Desert	74000 Country Club Dr., Ste E1/E2, Palm Desert CA 92260	760-674-8800	760-674-8646	● 1.5 GE		● 16 Slice	●	●	●
<input type="checkbox"/> Open MRI	72980 Fred Waring Dr., Ste A, Palm Desert CA, 92260	760-776-8001	760-776-9636		● 0.23T				
<input type="checkbox"/> La Quinta	79440 Corporate Center Dr., Ste 118, La Quinta, CA 92253	760-777-4646	760-777-4622		● 0.3T		●		●
<input type="checkbox"/> Palm Springs	1080 N. Indian Canyon, Ste 104 Palm Springs CA 92262	760-322-3036	760-322-3037	● 1.5 Toshiba		● 16 Slice	●		●

Please bring this Imaging Request Form, I.D., and your insurance card with you on the day of your exam.