

# SUMA MRI

Our File # \_\_\_\_\_

## PRECAUTIONARY SCREENING

Has patient ever had metal in eyes?

Yes No

Does patient have a cardiac pacemaker?

Yes No

Does patient have an aneurysm clip in brain?

Yes No

Does the patient have any shrapnel in body?

Yes No

Is patient pregnant?

Yes No

Dr. Name \_\_\_\_\_ Signature \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Does the patient have any special concerns or needs? Yes / No If yes please explain. This may include claustrophobic, mobility needs, height or weight, etc. \_\_\_\_\_

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Please provide the following information at the time of referral  
MAJOR MEDICAL AUTO WORK COMP OTHER  
D.O.I. \_\_\_\_\_

Policy Holder/Relationship: \_\_\_\_\_

Policy # \_\_\_\_\_ Claim # \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Claims Adjuster: \_\_\_\_\_ Phone: \_\_\_\_\_

PLEASE MAKE COPIES FOR FUTURE USE. THIS FORM MUST ACCOMPANY ALL REFERRALS.

☺ THANK YOU ☺