

PACIFIC IMAGING CENTER
625 – 9th Avenue, Ste. 130
Longview, WA 98632-1607
Phone: (360) 501-3444
Fax: (360) 577-1633

**When prior authorizing MRI's,
please use Longview Orthopedic
Associates as the facility with
Tax ID # 20-2707510**

Today's Date: _____

Appointment Information

Date: _____ **Check-in Time:** _____

Patient Information: (to be filled out by doctor's office)

Patient's Name: _____ Birthdate: _____

Patient's Address: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____ SSN: _____

Patient's Weight: _____ lbs. Height: _____ (Please notify PIC if the patient weighs over 350 lbs.)

Questions to the Patient:

Have you ever had an MRI/CT of the same body part? Y N If so, where? _____

Y N Are you claustrophobic? If yes, talk to your doctor about options.

Y N Have you ever had surgery to your brain or heart?

Y N Have you had any surgical procedures involving metal implants, such as plates or screws?

Y N Is there any chance you are pregnant?

Y N Have you done any metal grinding/welding without full eye protection?

Y N Have you ever had metal imbedded in your eye where you had to seek medical treatment to have it removed?

***If the answer is yes to any of the above questions, please contact Pacific Imaging Center.**

PLEASE HAVE PATIENT BRING INSURANCE CARDS/INFO TO THEIR APPOINTMENT.

Insurance: _____ Auth/Claim #: _____ Date of Injury: _____

Auth Needed?: _____ Comments: _____

_____ MVA? _____ PIP Coverage? Adj. Name and Phone #: _____

If MVA, does patient have secondary insurance? _____

MRI Information: (to be filled out by medical staff)

Anatomical Area: _____ Current
Diagnosis Code: _____

If lumbar, axial loading? Yes or No (please circle)

Reason for Exam: _____

Clinical Data: _____

Name of Referring Doctor: _____ Phone: _____ Fax: _____

Updated 2/09

Please fax this completed form to Pacific Imaging Center. THANK YOU!