



THE REGION'S PREMIER PROVIDER OF MRI SERVICES

TWO CONVENIENT LOCATIONS

REQUISITION AND APPOINTMENT FORM

1.5T MRI
32/36 HARRISON ST.
JOHNSON CITY, N.Y. 13790

607-729-1999
FAX 607-729-0031
TOLL FREE 877-STI MRI 1 (877-784-6741)

3T MRI
4417 VESTAL PARKWAY
VESTAL N.Y. 13850

www.southerntierimaging.com
Direct Scheduling Line 607-231-0071

Patient Name _____ Date of Birth _____

Appointment Date and Time _____ Patient Weight _____ Height _____

Insurance Information/Authorization # _____ Home Telephone _____

_____ Work Telephone _____

_____ Cell Telephone _____

Examination Requested _____

Diagnosis Code & Rule Out _____

Is there a History of the following:

- 1. Cardiac Pacemaker YES or NO
- 2. Intracranial Aneurysm Clip YES or NO
- 3. Has there **EVER** been any metal in the patient's eyes? YES or NO
- 4. Has patient had **ANY** prior studies pertaining to scan being done? YES or NO

Please make arrangements for patient to bring study with them.

You must bring this requisition and all pertinent x-rays, CT scans or diagnostic studies with you at the time of your appointment. - Delays may occur if this information is not available.

NOTE: Nurse will be contacting you for pertinent medical information.

NOTE: If there are any questions about metal prosthetic devices, surgical clips, or retained metal objects, please contact us at 729-1999.

If you cannot keep your appointment, please contact us immediately at 607-231-0071

DRS Name _____

Address _____

Phone _____

PHYSICIAN'S SIGNATURE: _____