Up Right MRI
OF COLORADO

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Patient Name:_____ Date of Birth:_____ ☐Male / ☐Female

Phone Number:_____ Authorization:_____Exp:_____

Prior authorization assistance ☐ ****In order to expedite the authorization process please fax <u>all</u> related office notes along with the order.**

☐Health Insurance / ☐Self-Pay / ☐Work Comp / ☐MVA Date of Injury or First Office Visit: _____

Insurance:_____ Policy/Claim Number:_____

Adjuster/Attorney Name and Phone Number:_____

Clinical History (Signs and Symptoms):_____

_____

MRI Requested: ☐**Exams may be modified at Radiologist's discretion** **Contrast**:** Upright MRI no longer provides contrast

☐Routine Brain ☐IAC's ☐Pituitary ☐MRA Head WO only ☐MRA Neck WO only ☐Orbits ☐Soft Tissue Neck	☐Upper Cervical/Cranio-Cervical Junction (Clivus – C3) Includes Flex/Ext ☐Cervical Spine ☐ Flexion/Extension ☐Thoracic Spine ☐Lumbar Spine ☐ Flexion/Extension ☐Sacrum/SI Joints/Bony Pelvis ☐Soft Tissue Pelvis	☐Shoulder ☐LT ☐RT ☐Upper Arm ☐LT ☐ RT ☐Elbow ☐LT ☐RT ☐Lower Arm ☐LT ☐RT ☐Wrist ☐LT ☐RT ☐Hand ☐LT ☐RT	☐Hip ☐LT ☐RT ☐Upper Leg ☐LT ☐RT ☐Knee ☐LT ☐RT ☐Lower Leg ☐LT ☐RT ☐Ankle ☐LT ☐RT ☐Foot ☐LT ☐RT

☐ Images sent with patient ☐ Images sent to office ☐ STAT Best Contact Phone #: _____

Physician's Name:_____Signature:_____

Contact Name:_____Phone:_____Fax:_____

Address: _____

NPI:_____ Tax ID:_____ Date:_____