



**NEUROLOGY &
NEUROSCIENCE ASSOCIATES, INC.**

Advanced MRI Services

Requisition and Orders 1.5 Tesla High-Field MRI

West Akron - Main Office
701 White Pond Dr., Suite 110
Akron, OH 44320
Phone: 330-572-1011
Fax: 330-572-1018

Patient name: _____ Ht: _____ Wt: _____

Phone: _____

Referring physician: _____

Referring physician phone: _____ Fax: _____

Reason for referral, diagnosis and/or symptoms: _____

PLEASE SEND PATIENT'S INSURANCE INFORMATION WITH THIS FORM

CONTRAST ___YES ___No

For contrast exams on patients over
60 years old/hypertension/diabetes,
a recent (6 week) creatinine level is needed.

BRAIN

___ Pituitary
___ Orbits
___ TMJS
___ IAC

SPINE

___ Cervical
___ Thoracic
___ Lumbar

BODY

___ Chest
___ Abdomen
___ Pelvis

OTHER

SEND DISK ___YES ___No

MRA

___ Circle of Willis
___ Carotids
___ Dissection Protocol
___ Run-offs

UPPER EXTREMITY

___ Shoulder
___ Elbow
___ Wrist
___ Right ___ Left

LOWER EXTREMITY

___ Hip
___ Knee
___ Ankle
___ Foot
___ Right ___ Left

If the patient has any of the following, please contact our office:

- | | |
|--|--|
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Cardiac Surgery |
| <input type="checkbox"/> Brain / Ear Surgery | <input type="checkbox"/> Implants |
| <input type="checkbox"/> Any surgery in the past 8 weeks | <input type="checkbox"/> Pregnant |

Referring
Physician SIGNATURE: _____

NNA staff will return this form with the information below once the patient is scheduled.

Patient scheduled date: _____ Time: _____ Location: _____