ALL INFORMATION IS REQUIRED BEFORE SENDING

PHYSICIAN ORDER FORM

Today's Date: _____

CP Healthcare
A Lien Friendly Company

2131 COMER AVENUE
COLUMBUS, GA 31904

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cph@cypresspartners.com

FAX ORDERS TO:
706.256.3454

QUESTIONS?
1-844-FOR-MRIS
1-844-367-6747

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Patient Name _____ DOB _____ Male or Female (circle)

Patient Cell Phone _____ Patient Email _____

Address _____

Date of Injury _____ Injury Type _____

Diagnosis _____

Referring Physician Printed _____ Signature _____

Physician Phone _____ Physician Fax _____

Firm _____ Case Manager _____ Case Manager Email _____ Firm Phone _____

Attorney Name _____ Email _____ Attorney/CM Cell Phone(s) _____

MRI

❍ Without Contrast ❍ Without & With Contrast ❍ As Per Radiologist

- ❑ Brain
- ❑ Pituitary
- ❑ IAC's
- ❑ Orbits
- ❑ Cervical-Spine
- ❑ Thoracic Spine
- ❑ Lumbar Spine
- ❑ MRCP
- ❑ Abdomen
- ❑ Bony Pelvis
- ❑ Female Pelvis
- ❑ Soft Tissue Neck
- ❑ Other_____
- ❑ Shoulder (R or L)
- ❑ Elbow (R or L)
- ❑ Wrist (R or L)
- ❑ Hip (R or L)
- ❑ Knee (R or L)
- ❑ Ankle/Heel (R or L)
- ❑ Foot/Forefoot (R or L)
- ❑ DTI
- ❑ NeuroQuant
- ❑ 3D
- ❑ With Arthrogram
- ❑ Claustrophobic

MRA ❑ Brain ❑ Neck ❑ Renals

CT

❍ Without Contrast ❍ With Contrast ❍ Without & With Contrast ❍ As Per Radiologist ❍ Allergic to Iodine

- ❑ Brain/Head
- ❑ Facial Bones
- ❑ Temp Bones/IAC's/Orbits
- ❑ Chest (Thorax)
- ❑ Abdomen
- ❑ Pelvis
- ❑ Upper Extremity (R or L)
- ❑ Lower Extremity (R or L)
- ❑ Lumbar Spine
- ❑ Cervical Spine
- ❑ 3D Recons
- ❑ CT Angiography - PE/ Head/Renal
- ❑ Other _____

ULTRASOUND

- ❑ Complete Abdomen
- ❑ Limited Abdomen
- ❑ Pelvic
- ❑ Other _____
- ❑ Venous Doppler Upper Extremity (R or L) / Bilateral (Circle One)
- ❑ Venous Doppler Lower Extremity (R or L) / Bilateral (Circle One)

XRAY

- ❑ MRI Screening / Orbits
- ❑ Chest (PA & Lateral)
- ❑ Ribs ❑ Bilat ❑ Left ❑ Right
- ❑ Cervical
- ❑ Thoracic
- ❑ Lumbar

OTHER

- ❑ Other _____
- ❑ Mammogram

COMMENTS: _____