



# FOOT AND ANKLE REFERRAL FORM



Appt. Date \_\_\_\_\_ AM

Appt. Time \_\_\_\_\_ PM

Arrival Time \_\_\_\_\_

Location \_\_\_\_\_

(See back for office addresses)

**TOO BUSY TO CALL? SCHEDULE YOUR APPOINTMENT ONLINE WHERE YOU HAVE 24/7 ACCESS!**

Scan the QR code above or visit [rmi.opendr.com](http://rmi.opendr.com) to schedule your appointment today!

Both patients and physician offices can schedule online.

PATIENT INFORMATION & LATERALITY

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  M  F Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Age: \_\_\_\_\_

Patient Phone #: (\_\_\_\_) \_\_\_\_\_

Ordering Physician: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

PRINT NAME

VALID SIGNATURE STAMPS ARE NOT VALID

Symptoms/reason for exam: (PLEASE INCLUDE LATERALITY, SPECIFIC SITE) \_\_\_\_\_

Other medical conditions RELEVANT TO THIS IMAGING STUDY \_\_\_\_\_

Pre-Authorization number: \_\_\_\_\_ Date range: \_\_\_\_\_

Physician preference for results:  Routine  STAT  Hold Patient  Release Patient

Call Report #: \_\_\_\_\_  Fax #: \_\_\_\_\_

CC: Doctor: \_\_\_\_\_ Other: \_\_\_\_\_

THIS SECTION MUST BE FULLY COMPLETED FOR ACCURACY, OR AN RMI EMPLOYEE WILL NEED TO CONTACT YOU PRIOR TO YOUR PATIENT'S EXAM.

**MEDICARE PATIENTS ONLY: BY LAW this section MUST be completed by the referring physician for Medicare advanced imaging: CT, MR, NUC, PET.**

DSN #: \_\_\_\_\_ AUC score: \_\_\_\_\_ HCPCS modifier (circle one): ME MF MG MH

CDSM: Careselect OR other: \_\_\_\_\_ G - \_\_\_\_\_ Date/time CDSM was consulted: \_\_\_\_\_

**PLEASE CALL FOR AN APPOINTMENT ON ALL EXAMS BELOW**

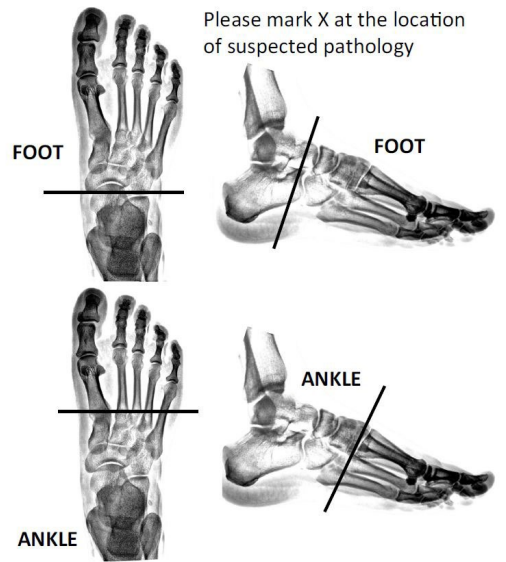
**RADIOLOGIST WILL DETERMINE APPROPRIATE USE OF CONTRAST FOR ALL APPLICABLE EXAMS BELOW**

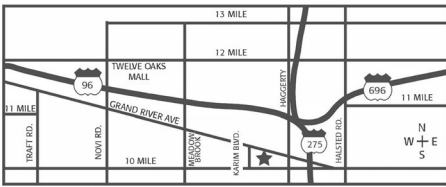
\*PATIENTS WITH PACEMAKER OR CARDIAC DEFIBRILLATOR (ICD) ARE NOT CANDIDATES FOR MRI EXAMS

<b>ANKLE</b>	<b>HINDFOOT/MIDFOOT</b> <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> MRI <input type="checkbox"/> CT
<b>FOOT</b>	<b>MIDFOOT/FOREFOOT</b> <input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT <input type="checkbox"/> MRI <input type="checkbox"/> CT
<b>ULTRASOUND</b>	<b>VENOUS</b> LOWER EXTEMITY <input type="checkbox"/> UNILATERAL <input type="checkbox"/> BILATERAL <b>ARTERIAL</b> LOWER EXTEMITY <input type="checkbox"/> UNILATERAL <input type="checkbox"/> BILATERAL <b>MSK</b> BODY PART _____ <input type="checkbox"/> COMPLETE <input type="checkbox"/> LIMITED
<b>MRA/CTA</b>	<b>MRA LOWER EXTEMITY</b> <input type="checkbox"/> UNILATERAL <input type="checkbox"/> BILATERAL <b>CTA LOWER EXTEMITY</b> <input type="checkbox"/> UNILATERAL <input type="checkbox"/> BILATERAL
<b>XRAY/DEXA</b>	<b>X-RAY</b> _____ <input type="checkbox"/> <b>BONE (DEXA) DENSITOMETRY</b>

## INDICATIONS

- FRACTURE OF CONTUSION
- HEEL PAIN
- LIGAMENT INJURY
- MASS (GANGLIONS, ETC.)
- MORTON NERUOMA
- OSTEOMYELITIS
- \_\_\_\_\_ TENDON PATHOLOGY
- OTHER \_\_\_\_\_
- DIAGNOSIS/IC9 CODE: \_\_\_\_\_
- SIGNS/SYMPTOMS: \_\_\_\_\_
- PREVIOUS X-RAY FINDINGS: \_\_\_\_\_

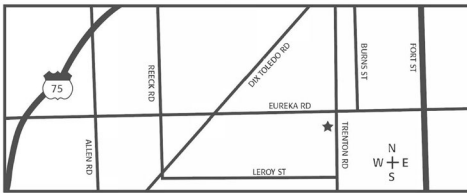




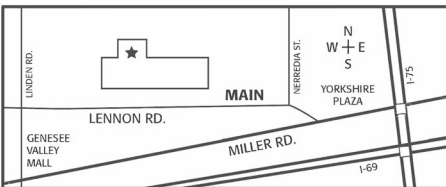
**NOVI** 24285 KARIM BLVD. SUITE A



**ROYAL OAK** 26454 WOODWARD AVE. SUITE A

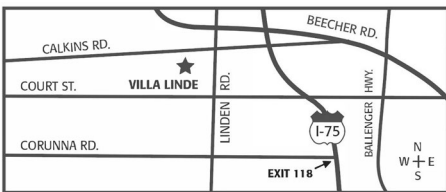


**SOUTHGATE** 15300 TRENTON RD



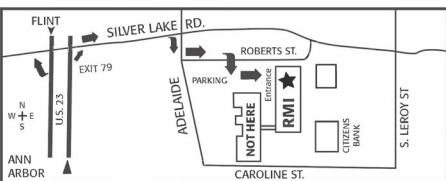
**MAIN OFFICE - MRI CENTER**

3346 LENNON RD., FLINT

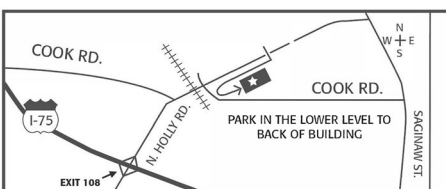


**VILLA LINDE - FLINT**

5059 VILLA LINDE PKWY, SUITE #25



**FENTON** 221 W. ROBERTS ST.



**GRAND BLANC** 8483 HOLLY RD.

**Novi Area (248) 536-0410**  
**Royal Oak Area (248) 543-7226**  
**Southgate Area (734) 281-6600**

**Genesee Area (810) 732-1919**  
**Lapeer Area (810) 969-4700**

## DIRECTIONS

Please follow instructions below. Proper preparation is important for good examination and your personal comfort. **Please bring this form, photo ID, medical insurance, and a complete list of all current medications with you at the time of your examination.**

### CT SCAN - ABDOMEN AND/OR PELVIS

- **If A.M. appointment:** Drink half of the first bottle of Readi-Cat at bedtime, the night before the exam.
- **If P.M. appointment:** Drink half of the first bottle of Readi-Cat 6 hours before exam time.
- Drink remaining half 2 hours prior to exam time.
- After drinking the second half, do not eat or drink anything else.
- Take all medications except diabetic medicines containing Metformin.
- Upon arrival, drink half of the second bottle of Readi-Cat. Please bring remaining portion into the exam room with you.

### CT SCAN - HEAD OR CHEST

- Nothing to eat 3 hours prior to exam, but you can drink water up to the time of your appointment.
- May take all medications.

### CT SCAN - SPINE OR EXTREMITIES

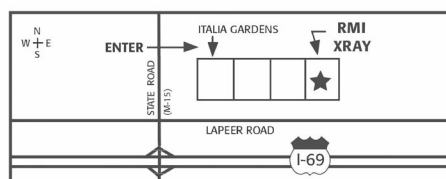
- No prep necessary.

### PET/CT SCAN

- Do not consume any food or drink for approximately 6 hours before your scan including candy, gum, mints, soda pop, cough drops or tobacco products.
- Avoid strenuous activities and exercise 24 hours prior to your exam.
- RMI staff will contact you prior to your appointment with further instructions.

### MRI/MRA

- Call us immediately if you have a pacemaker, defibrillator, aneurysm clips, or if you are pregnant, have a history of metal in your eyes, or have had brain, eye, ear, open heart surgery or internal stimulation devices.
- **MRI ABDOMEN** - Nothing to eat or drink 4 hours prior. **OR**
- **MRCP** - Nothing to eat or drink 6 hours prior.
- Our MRI scanner is specially designed to significantly decrease the problem of claustrophobia. Do not hesitate to discuss this issue with your doctor prior the examination.
- It is suggested that you wear sweat suits and that women wear sports bras or similar comfortable clothing.



**DAVISON** 1141 S. STATE RD. SUITE #26



**LAPEER** 1794 N. LAPEER RD. SUITE B