

## MRI and CT Head Imaging Request

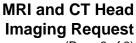
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Completing this survey can provide quicker turnaround. Additional comments can be made in the comments section. We encourage you to electronically forward relevant data/notes, especially results of previous imaging or tests. This form and all data submitted are legally considered an extension of the medical record with regard to privacy and accuracy. Any inconsistencies on this survey compared with the office medical record should be explained in the comments section.

MedSolutions reserves the right to request detailed information for the patient. Fax forms (non-urgent requests only) to 888.693.3210.

URGENT (Same Day) REQUESTS ARE ONLY ACCEPTED BY PHONE AT 888.693.3211.

	Dationt First Name		Dationt Lost Name:	Detient Leet Name:			
Member	Patient First Name:	ratient Last Name:	Patient Last Name:				
	DOB:	Member ID:	Group #:	Group #:		Health Plan:	
	Address:		City:	City:		Zip:	
Physician	Physician First Name:		Physician Last Nam	Physician Last Name:			
	Primary Specialty:	NPI:		Tax ID:			
	Address:		City:	City: ST: Zip:		Zip:	
	Phone #:	Fax #:	Contact Email:				
Facility	Facility Name:		Facility Tax ID:	Facility Tax ID:			
	Address:		City:		ST:	Zip:	
	Phone #:	Fax #:	NPI:	RETRO	Date of Se	ervice:	
Clinical	Check all applicable CPT® code(s) (REQUIRED): CT Head:						



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MED	SO	LU1	10	N S
	INTELLIG	ENT COST	MANAG	EMENT

7. Has there been a new onset of epileptic seizure?  ☐ Yes ☐ No ☐ Don't Know						
8. Is there a history of migraines?  ☐ Yes ☐ No ☐ Don't Know						
9. Has there been persistent unresponsive vertigo despite several days of treatment?  ☐ Yes ☐ No ☐ Don't Know						
10. Has a trial of physician-directed treatment been completed?  ☐ Yes ☐ No ☐ Don't Know						
<ul><li>11. Has physician-directed treatment of at least 3 weeks failed to help the problem?</li><li>☐ Yes ☐ No ☐ Don't know</li></ul>						
12. When did treatment start?  Less than 1 month ago  More than 1 month ago  No Treatment  Does not apply						
□ Don't Know						
13. Can the patient walk normally?  ☐ Yes ☐ No ☐ Don't Know						
14. Is there a known brain tumor?  Yes Don't Know						
Who will be the responsible contact for additional information, if requested, or questions concerning this request?						
Print Name:						
Additional Information/Comments:						
Check the appropriate box describing you:   Ordering Physician Facility Other						
Sign and Date Below:						
Print Name:						
Sign Name:						