

1.5T HIGH FIELD ULTRA-COMPACT SCANNER • THE WIDEST & SHORTEST BORE AVAILABLE

PATIENT NAME: _____ **DOB:** _____

DAY PHONE: _____ **CELL PHONE:** _____

Westwood Open MRI to Assist with Authorization: Yes No Authorization Number: _____ Expires: _____
If YES, please complete Clinical Notes below If NO, please see reverse for TAX ID and NPI

- | | | | |
|---|--|--|--|
| <p>SPINE (MRI)</p> <p><input type="checkbox"/> CERVICAL</p> <p><input type="checkbox"/> THORACIC</p> <p><input type="checkbox"/> LUMBAR</p> <p><input type="checkbox"/> SACRUM/SI JOINTS</p> <p><input type="checkbox"/> BRACHIAL PLEXUS</p> <p><input type="checkbox"/> LUMBAR PLEXUS</p> <p><input type="checkbox"/> REMOVE 3D SEQUENCE</p> <p>MR ANGIOGRAPHY (MRA)</p> <p><input type="checkbox"/> HEAD/CIRCLE OF WILLIS</p> <p><input type="checkbox"/> NECK/CAROTIDS
<small>(REQUIRES CONTRAST)</small></p> <p><input type="checkbox"/> THORACIC AORTA
<small>(REQUIRES CONTRAST)</small></p> <p><input type="checkbox"/> ABDOMINAL AORTA /RENALS
<small>(REQUIRES CONTRAST)</small></p> <p>HEAD AND NECK (MRI)</p> <p><input type="checkbox"/> BRAIN</p> <p><input type="checkbox"/> BRAIN W/ CSF FLOW</p> <p><input type="checkbox"/> BRAIN W/ DTI</p> <p><input type="checkbox"/> BRAIN W/ VOLUMETRIC ANALYSIS</p> <p><input type="checkbox"/> INTERNAL AUDITORY CANALS</p> <p><input type="checkbox"/> PITUITARY MACROADENOMA
<small>(REQUIRES CONTRAST)</small></p> <p><input type="checkbox"/> PITUITARY MICROADENOMA
<small>(REQUIRES DYNAMIC CONTRAST)</small></p> <p><input type="checkbox"/> SINUS</p> <p><input type="checkbox"/> ORBITS</p> <p><input type="checkbox"/> TMJ
<small>(REQUIRES CONTRAST)</small></p> <p><input type="checkbox"/> NECK (SOFT TISSUE)
<small>(REQUIRES CONTRAST)</small></p> <p><input type="checkbox"/> REMOVE 3D SEQUENCE</p> | <p>BODY (MRI)</p> <p><input type="checkbox"/> CHEST</p> <p><input type="checkbox"/> ABDOMEN
<small>(REQUIRES CONTRAST)</small></p> <p><input type="checkbox"/> ENTEROGRAPHY</p> <p><input type="checkbox"/> PELVIS (SOFT TISSUE)
<small>(REQUIRES CONTRAST)</small></p> <p><input type="checkbox"/> PELVIC FLOOR</p> <p><input type="checkbox"/> PROSTATE
<small>(REQUIRES CONTRAST)</small></p> <p><input type="checkbox"/> PENIS</p> <p><input type="checkbox"/> SCROTUM</p> <p><input type="checkbox"/> VITAL BODY SCREENING
<small>(REQUIRES CONTRAST)</small></p> <p><input type="checkbox"/> CHOLANGIOGRAM/MRCP
<small>(REQUIRES CONTRAST)</small></p> <p><input type="checkbox"/> REMOVE 3D SEQUENCE</p> | <p>UPPER EXTREMITIES (MRI) <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> SHOULDER</p> <p><input type="checkbox"/> HUMERUS <input type="checkbox"/> PROXIMAL <input type="checkbox"/> DISTAL</p> <p><input type="checkbox"/> ELBOW</p> <p><input type="checkbox"/> FOREARM <input type="checkbox"/> PROXIMAL <input type="checkbox"/> DISTAL</p> <p><input type="checkbox"/> WRIST</p> <p><input type="checkbox"/> HAND</p> <p><input type="checkbox"/> FINGER <input type="checkbox"/> 1ST <input type="checkbox"/> 2ND <input type="checkbox"/> 3RD <input type="checkbox"/> 4TH</p> <p><input type="checkbox"/> THUMB</p> <p><input type="checkbox"/> REMOVE 3D SEQUENCE</p> | <p>LOWER EXTREMITIES (MRI) <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> B</p> <p><input type="checkbox"/> HIP/ PELVIS (BONY)</p> <p><input type="checkbox"/> THIGH/FEMUR <input type="checkbox"/> PROXIMAL <input type="checkbox"/> DISTAL</p> <p><input type="checkbox"/> KNEE</p> <p><input type="checkbox"/> TIB-FIB/CALF <input type="checkbox"/> PROXIMAL <input type="checkbox"/> DISTAL</p> <p><input type="checkbox"/> ANKLE/HINDFOOT</p> <p><input type="checkbox"/> FOREFOOT/MIDFOOT</p> <p><input type="checkbox"/> FOREFOOT/PHALANGES <small>(E.G. MORTON'S NEUROMA, SESAMOID DYSFUNCTION, PLANTAR PLATE INJURY)</small></p> <p><input type="checkbox"/> REMOVE 3D SEQUENCE</p> |
|---|--|--|--|

- ULTRASOUND**
- ABDOMEN & PELVIS**
- ABDOMEN COMPLETE
- PELVIS TRANSABDOMINAL/TRANSVAGINAL
- PELVIS TRANSABDOMINAL ONLY
- PELVIS LIMITED, BLADDER ONLY
- RENAL ARTERIAL COMPLETE
- KIDNEY BILATERAL ABDOMINAL AORTA
- EXTREMITY DOPPLER**
- VENOUS ARTERIAL
- LOWER L / R / B UPPER L / R / B
- OBSTETRICS**
- OB COMPLETE OB UNDER 14 WKS
- OTHER**
- THYROID SCROTUM CAROTID
- PROSTATE HEAD/NECK SOFT TISSUE
- PAROTID GLAND
- SOFT TISSUE, SPECIFY: _____
- SPECIFY: _____

ADVANCED BRAIN AND NEUROLOGICAL IMAGING INDICATIONS (CHECK ALL THAT APPLY):

<input type="checkbox"/> ADDICTION	<input type="checkbox"/> ADHD/ADD	<input type="checkbox"/> ALZHEIMERS	<input type="checkbox"/> ANXIETY
<input type="checkbox"/> AUTISM	<input type="checkbox"/> CHRONIC PAIN	<input type="checkbox"/> CONCUSSION	<input type="checkbox"/> CROHN'S DISEASE
<input type="checkbox"/> DEMENTIA	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> EPILEPSY	<input type="checkbox"/> FIBROMYALGIA
<input type="checkbox"/> HASHIMOTO'S E.E.	<input type="checkbox"/> INTRACRANIAL MASS	<input type="checkbox"/> MEMORY LOSS	<input type="checkbox"/> MIGRAINES
<input type="checkbox"/> MS	<input type="checkbox"/> OCD	<input type="checkbox"/> PARKINSON'S	<input type="checkbox"/> PRE-OP PLANNING
<input type="checkbox"/> PTSD	<input type="checkbox"/> SEIZURES		

OTHER: _____

A CUSTOMIZED FUNCTIONAL MRI PROTOCOL WILL BE PERFORMED BASED UPON THE ABOVE INDICATIONS

SPECIAL IMAGING REQUEST: _____

STAT: Physician's Mobile Number: _____ WITHOUT AND WITH IV CONTRAST: NO YES

OBTAIN LABS ONSITE: YES NO, LABS PROVIDED BY PATIENT CREATININE: _____ DATE: _____

PLEASE INCLUDE AS MUCH APPLICABLE/REQUIRED INFORMATION FROM THE PATIENT'S CLINICAL NOTES FOR PRE-AUTHORIZATION

Symptoms/Prior History: _____
(PERTAINING TO CONDITION)

Initial Clinician Eval Date: _____ Face-to-Face Eval Date: _____ Referred to a Specialist? Yes No

Conservative Tx: <input type="checkbox"/> PT. <input type="checkbox"/> Rx <input type="checkbox"/> Other/Describe: _____	Conservative Tx: <input type="checkbox"/> PT. <input type="checkbox"/> Rx <input type="checkbox"/> Other/Describe: _____
Tx Start Date: _____ Tx Stop Date: _____	Tx Start Date: _____ Tx Stop Date: _____
Duration: <input type="checkbox"/> greater than 6 weeks Failed Tx? <input type="checkbox"/> Yes <input type="checkbox"/> No	Duration: <input type="checkbox"/> greater than 6 weeks Failed Tx? <input type="checkbox"/> Yes <input type="checkbox"/> No

Is this study for a Pre-Operative Evaluation? Yes No Additional Test(s): _____ Results: _____

Previous Imaging: X-Ray CT Ultrasound MRI PET DOE: _____ RESULTS: Abnormal Normal

DIAGNOSIS: _____

Physician's Signature: _____ Phone: _____ Fax: _____

Physician's Name: _____ Contact Person: _____

Physician's signature above requests and directs Centrelake Medical Imaging, Inc to act as the physician's agent in initiating and acquiring authorization for payments from all relevant insurance and/or government payers for all imaging services requested above.

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DIRECTIONS TO WESTWOOD MEDICAL PLAZA:

From the 405 fwy:

- Exit Wilshire Blvd EAST
- Turn RIGHT onto Wilshire Blvd
- Turn LEFT onto Gayley Avenue

From Beverly Hills:

- Take Wilshire Blvd WEST towards the 405
- Turn RIGHT on Gayley Avenue

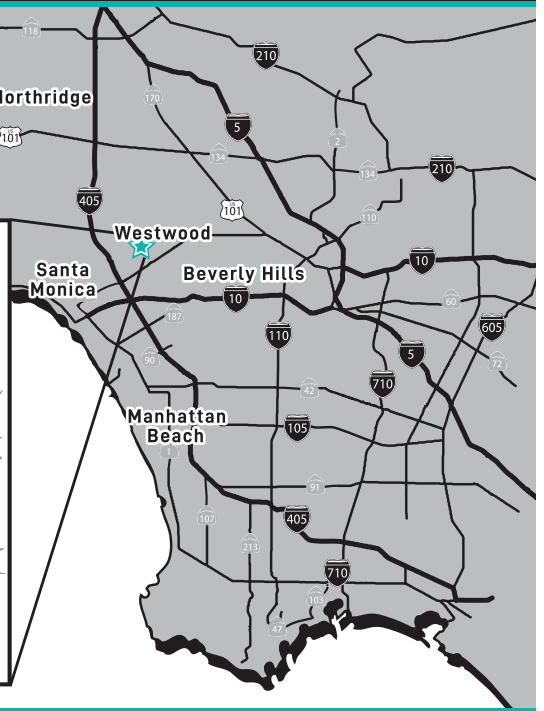
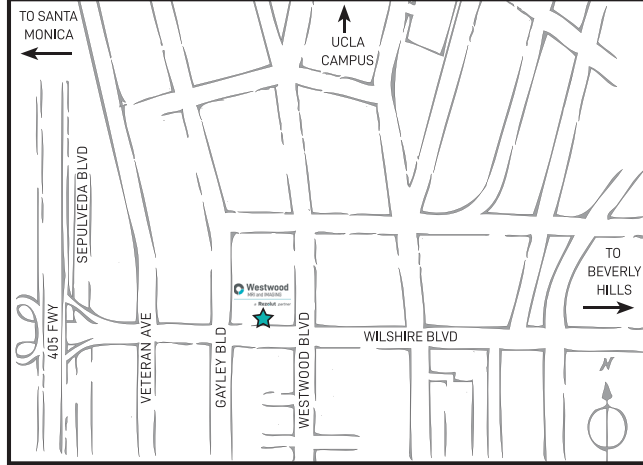
From Santa Monica:

- Take Wilshire Blvd EAST towards Beverly Hills
- Turn LEFT on Gayley Avenue

ENTER PARKING STRUCTURE:

- (After turning onto Gayley) Make an immediate RIGHT into the first driveway
- Park on the first level of the parking structure
- Take the elevator in the lobby to the (M) Mezzanine Level

14 miles from Northridge
4 miles from Santa Monica
3 miles from Beverly Hills
15 miles from Manhattan Beach



Westwood Open MRI offers a boutique spa-like experience to make our patients feel comfortable and relaxed. In addition to state-of-the-art equipment, our staff is expertly trained in accommodating VIP, claustrophobic, obese, geriatric, and pediatric patients.



WE MAKE SCHEDULING FAST AND EASY!

CHOOSE 1, 2 OR 3 TO SUBMIT YOUR ORDER:

1 Email referral to:
wworders@rezolut.com



2 Call in a verbal referral to:
310-208-3100 ext 1



3 FAX referral to:
310-208-3101



4 View results Online or via Fax
the next business day by 5pm
www.westwoodopenmri.com



LET WESTWOOD DO THE WORK FOR YOU!

WE WILL:

- OBTAIN PRE-AUTHORIZATION
- CALL TO SCHEDULE THE PATIENT
- PROVIDE RESULTS THE NEXT BUSINESS DAY!

- Centrelake Medical Group, Inc is an In-Network Provider for over 200 Major PPO Insurances
- We also accept Worker's Compensation Insurance and Personal Injury Liens
- We can schedule in English, Russian, Armenian and Spanish

If physician's office is obtaining pre-authorization, please use the following information:

Centrelake Medical Group, Inc
10921 Wilshire Blvd
Los Angeles, CA 90024

- NPI 1790494128
- TIN 65-1251372