OneCore Health
Open MRI

Patient Name_____

Date of Exam_____ Time of Exam_____ AM PM

Exam Requested_____

_____

Diagnosis Code_____

History and Symptoms_____

_____

Physician_____ Date_____

WHITE COPY: MRI **YELLOW COPY:** Physician

1044 SW 44th Street, Oklahoma City, OK 73109 | Suite 108 | **T** 405-632-7333 | **F** 405-616-2673

☐ Call Report ☐ Send Images
☐ Send Report ☐ Send CD/Disk

PATIENT INFORMATION

Claustrophobic	**YES** ☐	**NO** ☐
Pacemaker	**YES** ☐	**NO** ☐
Hearing Implants	**YES** ☐	**NO** ☐
Diabetes	**YES** ☐	**NO** ☐
History of Surgery	**YES** ☐	**NO** ☐
Cardiac Stents	**YES** ☐	**NO** ☐
Any metal in the body	**YES** ☐	**NO** ☐

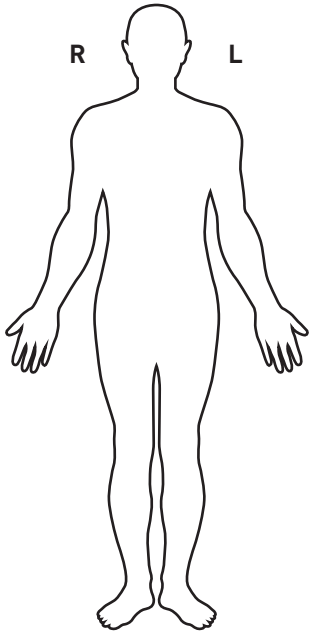
Creatinine_____ Date_____

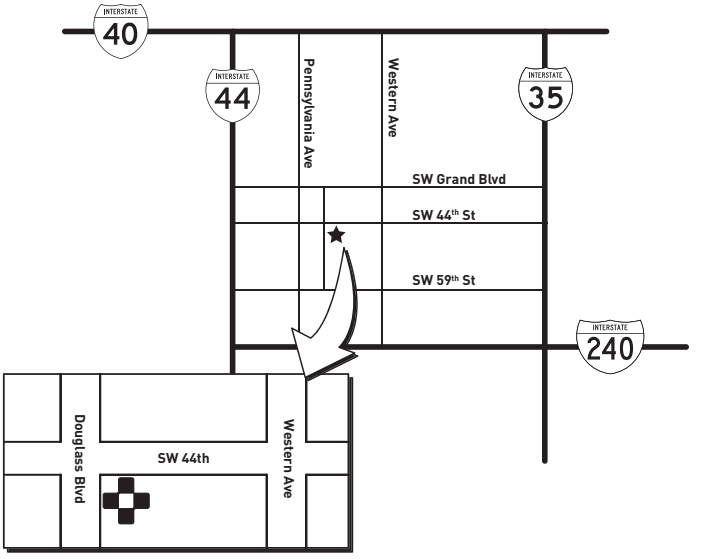
ALLERGIES_____

_____

_____

Please send any pertinent MRI reports with patient. Thank you for the referral.





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