MR#:_____ Dr's #:_____

821 Lexington Road, Clovis, NM 88101 | 575-763-6144

STAT READ: YES OR NO

Patient Name:_____ DOB:_____

Gender:_____ Date of Exam:_____

Referring Doctor:_____ _____
(last name) (first name)

Examination Performed:_____
(modify left, right, or bilat)

Chief Complaint:_____

Duration of Symptoms:_____

History of Injury:_____

Prior Surgery to Exam Site and Date:_____

_____

Relevant Medical History:_____
(HBP, Diabetes, etc)

<u>*DO NOT FILL OUT – The Following is for MRI Tech Only*</u>

Pertinent Prior Imaging Studies:_____

Dr.'s Reason for Exam:_____

Technologist Notes:_____