Cayman Medical Ltd.
Crowne Square - 71 Eastern Ave - PO Box 32322 -
George Town, KY1-1209 - Cayman Islands
Tel: (345) 623-1000 || Fax: (345) 623-1001
MRI@medical.ky || www.medical.ky

MRI Request Form

Name - Last:	First:	Middle:	Date of Birth: DD/MM/YYYY
Phone - Home:	Cell:	Sex:	Height: Ft/In Weight: Lbs
Insurance Name: Policy Owner:	Member ID#:	Group ID#:	Plan Name:
Metal or electronic Implants Pacemaker/ Defibrillator Aneurysm Clips	Heart, Kidney or Liver disease H/O Stroke Able to stand for 15 mins?	Diabetic HTN Cancer	Pregnant or breastfeeding Allergies:

Prior Imaging (Location and date):	Desired appointment date: *Standard* / *ASAP* / *Urgent*
Indication/Diagnosis (+ ICD-10 Code):	
Special notes:	

Requested Procedures (please check available studies in the white fields)

Description	Contrast?		Weight-Bearing	Dynamic	In-Motion
	Without	With & WO			
MRI Brain					
MRI Sella/Pituitary					
MRI Internal Auditory Canal (IAC)/Cerebellopontine Angle					
MRI Orbit/Face					
MRI Temporomandibular Joint(s)					
MRI Neck					
MRI Cervical Spine					
MRI Thoracic Spine					
MRI Lumbar Spine					
MRI Upper Extremity Non-Joint (please specify: ______________)					
MRI Upper Extremity Joint (please specify: __________________)					
MRI Lower Extremity Non-Joint (please specify: ______________)					
MRI Lower Extremity Joint (please specify: __________________)					

Practice Name________________________________ Practice Phone___________Practice Fax___________

Physician Name_____________________ Physician Signature_______________________ Date DD/MM/YYYY

We encourage referring doctors to use our doctor portal, which allows instant orders, instant notifications and instant access to reports and imaging:

https://portal.medical.ky