



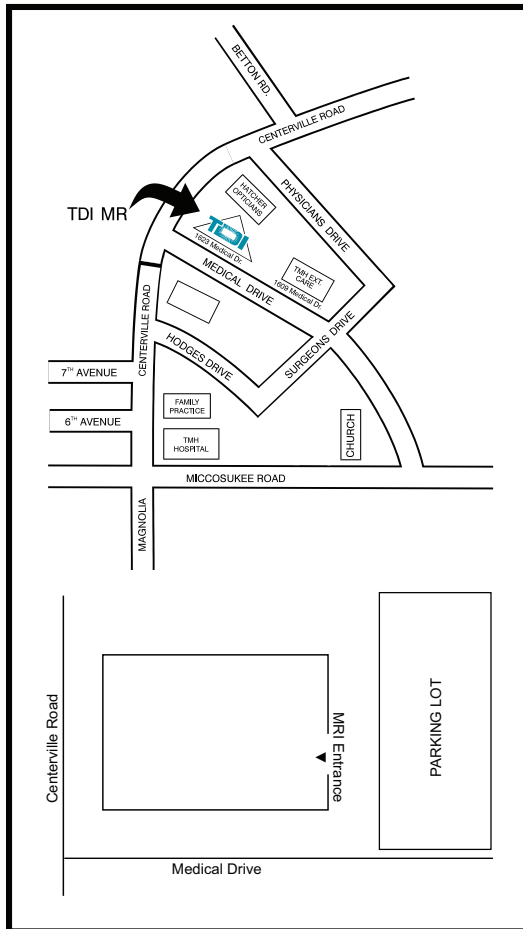
Tallahassee Diagnostic Imaging
 1623 Medical Drive, Tallahassee, FL 32308
 Phone: (850) 656-2261 Fax: (850) 671-1912 Website: www.tdic.org

MRI

Patient Name: _____ Date of Birth: _____ Weight _____ #'s

Address: _____ Phone # (H): _____ (W): _____ Cell#: _____

Appointment Date & Time: _____ Authorization Number: _____



Examination Requested: _____

Contrast at Radiologist's discretion.

Perform blood creatinine per TDI protocol if no labs done within 6 weeks of scheduled study.
(Contrast patients only) (HTN / Diabetes / ▲ 60 years of age / single kidney / renal cancer)

*If patient has had labs within 6 weeks, please fax results.

Pertinent History: _____

ICD 9 Code(s): _____

IMPORTANT: MUST BRING THIS FORM WITH YOU TO YOUR APPOINTMENT!!!

 Physician's Signature

Please do not bring children
 to be left unattended.

FAX A COPY TO TDI & GIVE PATIENT A COPY