MedSolutions
THE LEADER IN RADIOLOGY MANAGEMENT SOLUTIONS

PRI-SM

MRI Knee Imaging Request

Completion of this form is the minimum required information to start a case. In some cases, more clinical information is required. MedSolutions reserves the right to request detailed information for the patient. Fax requests (non urgent requests only) to MedSolutions **(888) 693-3210.**

URGENT (Same Day) REQUESTS ARE ACCEPTED BY PHONE ONLY AT (888) 693-3211.

Member Information

Patient First Name:		Patient Last Name:		
DOB:	Mbr ID:	Group #	Health Plan:	
Address:	City:		ST	Zip

Physician Information

Physician First Name:		Physician Last Name:		
Primary Specialty:	NPI:		Tax ID:	
Address:	City:		ST	Zip:
Phone #:	Fax #:	Contact Email:		

Facility Information

Facility Name:		Facility Tax ID:		
Address:	City:		ST	Zip:
Phone #:	Fax #:	☐ RETRO Date of Service:		
ICD-9:	**Please circle one: CPT®** Code(s): 73721 73722 73723			
☐ Without Contrast	☐ With Contrast	☐ Without and With Contrast		

Clinical Information

1. Has a specialist evaluation been completed?	☐ Orthopedist	☐ Sports Medicine	☐ Other		☐ No	☐ Don't Know
2. Has there been a recent injury?	☐ W/In past 2 Months	☐ Greater than 2 Months			☐ No	☐ Don't Know
3. Has an X-Ray been done?				☐ Yes	☐ No	☐ Don't Know
4. Does the patient have a history of cancer other than ordinary skin cancer?				☐ Yes	☐ No	☐ Don't Know
5. Is this study to evaluate arthritis?				☐ Yes	☐ No	☐ Don't Know
6. Are the knee ligaments stable on examination?				☐ Yes	☐ No	☐ Don't Know
7. Is there a positive McMurray test?				☐ Yes	☐ No	☐ Don't Know
8. Does the knee have full extension upon examination?				☐ Yes	☐ No	☐ Don't Know
9. Has the patient had conservative treatment? Physical therapy, medication or rest	☐ 3 weeks or less	☐ 4 weeks	☐ 6 weeks	☐ 8 weeks or more	☐ None	☐ Don't Know
10. Please check the appropriate box describing you:				☐ Ordering Physician	☐ Facility	☐ Other _____
11. Does the ordering physician have an ownership stake, management or lease agreement covering the imaging requested with the rendering facility?				☐ Yes	☐ No	☐ Don't Know

Signature

Please Sign and Date Below:

Responsible Contact:

Print Name: _____ **Date:** _____

Sign Name: _____ ☐ **MD** ☐ **RN** ☐ **LPN** ☐ **PA** ☐ **NP** ☐ **OTHER**