Glendale Diagnostic Imaging Network

4910 Van Nuys Blvd. Suite 108, Sherman Oaks, CA 91403
Tel: (818) 986-8215 ◆ Fax: (818) 986-9582 ◆ www.glendalediagnostic.com

UPRIGHT MRI REQUEST FORM

Patient Name: _____ Phone: _____

Referring Physician: _____ Phone: _____

Clinical Impression / Diagnosis: _____

Physician's Signature: _____ Date: _____

Please Select The Examination and The Corresponding Position Below

❑ Without Contrast ❑ With Contrast ❑ W & W/O Contrast

MRI with Arthrogram ❑ Yes ❑ No

❑ Cervical Spine




❑ Neutral ❑ Flexion ❑ Extension ❑ Lateral Bending ❑R ❑ L

❑ Lumbar Spine – Seated



❑ Neutral ❑ Flexion ❑ Extension

❑ Lumbar Spine – Standing




❑ Neutral ❑ Flexion ❑ Extension ❑ Lateral Bending ❑R ❑ L

❑ Lower Extremity Joints

❑ Hip ❑ R ❑ L
❑ Knee ❑ R ❑ L
❑ Ankle ❑ R ❑ L
❑ Foot ❑ R ❑ L

❑ Upper Extremity Joints

❑ Shoulder ❑ R ❑ L
Specify Angle: _____
❑ Elbow ❑ R ❑ L
❑ Wrist ❑ R ❑ L

❑ Recumbent Only

❑ Pelvis
❑ Brain Specify: _____
❑ Spine Specify: _____
❑ Joint Specify: _____
❑ Other Specify: _____

❑ MRA

❑ Circle of Willis ❑ Carotid Arteries
❑ Other: _____

❑ Thoracic Spine

❑ Seated ❑ Standing

❑ Other: _____

Transportation is Available Upon Request