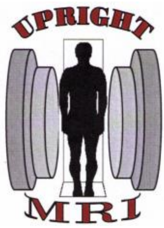

Diagnostic Imaging Network

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

UPRIGHT MRI REQUEST FORM

Patient Name: ______________________________ DOB: _____/_____/__________

Patient Phone: ______________________________ Email: ______________________

Referring Provider: ___________________________ Phone: ______________________

Clinical Impression / Diagnosis: ____

Provider's Signature: ________________________________ Date: _____/_____/________

Please Select The Examination and The Corresponding Position Below

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

❑ 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

❑ Thoracic Spine

❑ Seated ❑ Standing

❑ Upper Extremity Joints

❑ Shoulder ❑ R ❑ L
Specify Angle: ____________

❑ Elbow ❑ R ❑ L
❑ Wrist ❑ R ❑ L

❑ Lower Extremity Joints

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

❑ Recumbent Only

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