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ALERT!!!
PLEASE SEE REVERSE SIDE FOR INSTRUCTIONS

Patient Name William Thompson Date 12/5/24
Diagnosis cervical DDD, osteophyte

MRI
__ Cervical
__ Thoratic
__ Lumbar
other _____
AUTHORIZATION _____
__ without contrast
__ with contrast
PLEASE GIVE PATIENT DISCS (OR FILMS)

CT
X Cervical
__ Thoratic
__ Lumbar
other _____
AUTHORIZATION _____
X without contrast
__ with contrast
PLEASE GIVE PATIENT DISCS (OR FILMS)

BONE SCAN
__ Cervical
__ Thoratic
__ Lumbar
other _____
AUTHORIZATION _____
PLEASE GIVE PATIENT DISCS (OR FILMS)

EMG's __ Upper Extremities __ Lower Extremities
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BONE DENSITY
PLEASE FAX RESULTS TO 973-686-0701

SIGNATURE _____