

# RAPID MRI

FAST. ACCURATE. COMFORTABLE.



## MRI

- Same day scheduling
- Fast scan times
- 24 hour reporting
- Perfect for large sized and claustrophobic patients

**At Rapid MRI  
your health means  
everything to us.**

We only offer the highest quality, gold standard of imaging that is available.



**Higher levels of  
patient comfort**



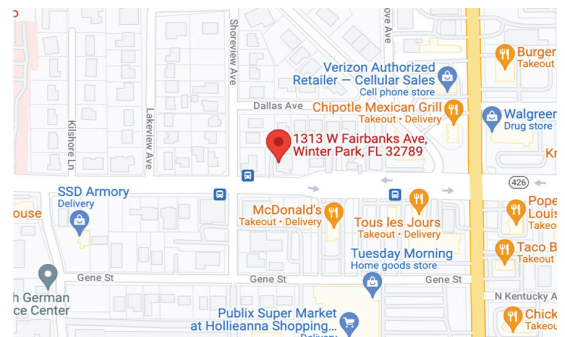
**Free transportation  
provided for patients**



**Specializing in personal  
injury and LOPs**

## WHY RAPID MRI?

Getting an MRI can enhance the validity of a car accident injury claim. There are several injuries that cannot be identified or verified visually through an x-ray that are revealed with an MRI. You can trust **RAPID MRI**.



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fax: +407-634-3202



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**SATURDAY APPOINTMENTS AVAILABLE**

# RAPID MRI

FAST. ACCURATE. COMFORTABLE.

TO SCHEDULE CALL  
**407-335-4652**

PATIENT NAME: \_\_\_\_\_ M F DATE: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ D.O.B: \_\_\_\_\_ S.S#: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_ DATE OF ACCIDENT: \_\_\_\_\_

**SEDATION NEEDED:** YES NO **METAL IMPLANTS:** YES NO **ICD/PACEMAKER/STENT:** YES NO **PREGNANT:** YES NO  
**BODY PIERCINGS:** YES NO **BRACES:** YES NO **TATTOOS/PERMANENT MAKEUP:** YES NO **BULLETS/BB'S:** YES NO  
**INSULIN PUMP:** YES NO

INSURANCE: \_\_\_\_\_ PHONE: \_\_\_\_\_

POLICY #: \_\_\_\_\_ CLAIM #: \_\_\_\_\_

ATTORNEY: \_\_\_\_\_ PHONE: \_\_\_\_\_

- ☐ BRAIN  
☐ IAC's  
☐ TMJ ☐ RT ☐ LT  
☐ ORBITS/FACE/NECK  
☐ OTHER  
☐ WITHOUT CONTRAST  
☐ WITH AND WITHOUT CONTRAST

- ☐ CERVICAL ☐ THORACIC ☐ LUMBAR ☐ SI JOINTS ☐ SACRUM/COCCYX  
☐ UPPER EXTREMITY ☐ RT ☐ LT  
☐ UPPER ARM (Humerus) ☐ LOWER ARM (Ulna/Radius) ☐ HAND  
☐ UPPER EXTREMITY JOINTS ☐ RT ☐ LT  
☐ SHOULDER ☐ ELBOW ☐ WRIST  
☐ LOWER EXTREMITY ☐ RT ☐ LT  
☐ UPPER LEG (Femur) ☐ LOWER LEG (Tibia/Fibula) ☐ FOOT (Tarsals/Metatarsals)  
☐ LOWER EXTREMITY JOINTS ☐ RT ☐ LT  
☐ HIP ☐ KNEE ☐ ANKLE  
☐ PELVIS  
☐ WITHOUT CONTRAST ☐ WITH AND WITHOUT CONTRAST

I hereby authorize Rapid MRI to act on my behalf to obtain any authorization for any testing that I have ordered for my patient.  
I hereby certify that the tests are medically necessary for the diagnosis and treatment of this patient.

**PHYSICIAN NAME:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**OFFICE LOCATION:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

**PHYSICIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_