UCLA Health System
Radiology

MRI Scheduling:

Hours: 7:30 am - 4:30 pm *(closed 12 noon - 1:15 pm)*

Phone: (310) 301-6800 (press option 5 then 1) - Fax (310) 794-9035

Thank you for referring your patient, _____ *(pt name),* to Dr. James Collins. To schedule your patient we need the following information.:

☐ Prescription
(Please make sure the order has the complete information, i.e. procedure requested, diagnosis, and history)

Dr. Collins performs the following exams for Brachial Plexus study. Please make sure the authorizations apply to all as noted.

- MRI Upper Extremity, **bilateral** - (cpt 73221-50)
- MRA Upper extremity - (cpt 73225)
- Chest X-ray 2 views - (cpt 71020)

☐ Authorization: _____
(The exams MUST be authorized as noted above before any scheduling is begun.)

- *For **Worker's Comp** we need:*
  Claim Number: _____
  DOI: _____
  Adjuster: _____
  Authorizer/approved by: _____

☐ History and Physical
*(Must have been done within **2 months** of the appointment date.)*

Is this a NEW patient to UCLA?
☐No: Please provide their UCLA ID number or DOB
_____
☐Yes: Please provide the following information:
Soc Sec Number: _____
DOB: _____

Patient's daytime phone number: (_____) _____

Please indicate the surgery date if the procedure needs to be scheduled before then:
_____ *(date)*

Referring provider (full name): _____ _____
(first name) (last name)

Referring provider phone number: (_____) _____

Referring provider fax number: (_____) _____

http://tosinfo.com

http://tosinfo.com/mri/images/img_gallery.html