applied fmri INSTITUTE
858.444.3595 appliedfmri.org

# Referring/ Ordering Request

**Fax To the Applied fMRI Institute (858) 444-3599**

**Patient Name:** **Date:**

**Test:** MRI to rule out Chronic Cerebrospinal Venous Insufficiency (CCSVI)

**Patient is MR Safe in 3T MRI:** YES NO

**Kidney Function is Within Normal Limits:** YES NO

**Physician Signature**

**Physician Printed Name:**
**Phone:**
**Address:**

*(May also be supplied on the physician's prescription)*

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# Contact Information

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Name ________________________________ Male /Female

Date of birth _________Height ___ Weight ____ Age ___

Mailing address ___________________________________________

___________________________________________________________

Phone Number _____________________________

Cell Number (# you are traveling with) ______________________

Email address _____________________________________________

Name of Referring Physician:________________________________

Date of Diagnosis:_____________

Are you on Disability?_____If yes, when did you go on?__________

Do you have mobility restrictions? ________
If so, can you bear weight?__________

Do you have problems with incontinence? _________
If so, do you use an external collection device?__________

**For Office Use Only:**
Subject ID: