

**MRI Spine - FAX – Evaluate Neck/Back pain**

Completing this survey can provide quicker turnaround. Additional comments can be made in the comments section. We encourage you to electronically forward relevant data/notes, especially results of previous imaging. This form and all data submitted are legally considered an extension of the medical record with regard to privacy and accuracy. Any inconsistencies on this survey compared with the office medical record should be explained in the comments section. MedSolutions reserves the right to request detailed information for the patient. Fax forms (*non-urgent requests only*) to **888.693.3210**

**URGENT (Same Day) REQUESTS ARE ONLY ACCEPTED BY PHONE AT 888.693.3211.**

<b>Member</b>	Patient First Name:		Patient Last Name:		
	DOB:	Member ID:	Group #:	Health Plan:	
	Address:		City:	ST:	Zip:
<b>Physician</b>	Physician First Name:		Physician Last Name:		
	Primary Specialty:	NPI:	Tax ID:		
	Address:		City:	ST:	Zip:
	Phone #:	Fax #:	Contact Email:		
<b>Facility</b>	Facility Name:		Facility Tax ID:		
	Address:		City:	ST:	Zip:
	Phone #:	Fax #:	NPI:	<input type="checkbox"/> RETRO Date of Service:	
<b>Clinical</b>	<b>Check circle all applicable CPT® code(s):</b> MRI C-Spine : <input type="checkbox"/> 72141 <input type="checkbox"/> 72142 <input type="checkbox"/> 72156 MRI T-Spine: <input type="checkbox"/> 72146 <input type="checkbox"/> 72147 <input type="checkbox"/> 72157 MRI L-Spine <input type="checkbox"/> 72148 <input type="checkbox"/> 72149 <input type="checkbox"/> 72158 <input type="checkbox"/> Other: _____				
	<b>ICD-9 Code (Required Field):</b> _____				
	1. Is this request to rule out or evaluate any of the following? Please choose <b>only</b> the primary reason. <input type="checkbox"/> Back/neck pain <input type="checkbox"/> Multiple Sclerosis ( <i>This is the incorrect fax form. Please use <b>MRI Spine - Multiple Sclerosis fax form</b></i> ) <input type="checkbox"/> Known or suspected spine trauma ( <i>This is the incorrect fax form. Please use <b>MRI Spine – Trauma fax form</b></i> ) <input type="checkbox"/> Metastatic cancer <input checked="" type="checkbox"/> Surgical planning/Pre-op <input type="checkbox"/> None of the above ( <i>Please enter reason in the comment section at the end of the survey.</i> ) <input type="checkbox"/> Don't know				
2. Provide the following dates: <input type="checkbox"/> Date of the first office visit with any physician for this episode (mm/dd/yyyy) _____ <input type="checkbox"/> Date of the most recent office visit for this episode (mm/dd/yyyy) _____ <input type="checkbox"/> Don't Know					

3. What are the current symptoms? (Choose all that apply)

- No symptoms
- Lower back pain
- Hip or thigh pain
- Leg pain that goes below the knee
- Neck pain
- Upper back pain (*hover hint: middle or upper back*)
- Arm pain that goes into forearm or hand
- None of the above
- Don't know

4. How long has there been physician-directed treatment or observation since the onset of this episode? (*hover hint: Physician directed treatment might include the following: pain medicine, steroids, steroid injection, physical therapy and/or physician-monitored home exercise program*)

- No physician directed treatment
- Three weeks or fewer
- Four weeks
- Five weeks
- Six weeks
- Seven weeks
- Eight weeks or more
- Don't Know

5. How have symptoms changed with physician directed treatment or observation? (*hover hint: Physician directed treatment might include the following: pain medicine, steroids, steroid injection, physical therapy and/or physician-monitored home exercise program.*)

- No physician directed treatment or observation
- Symptoms have improved
- Symptoms have stayed the same
- Symptoms have worsened
- Don't know

6. Were any of the following found on a physical exam performed for this episode? (Choose all that apply)

- No physical exam performed
- Weakness in extremity(ies) on exam (*hover hint: not patient reported weakness*)
- Limited range of motion
- Foot drop
- Upper motor neuron signs (*hover hint: Hoffman's, Babinski, Hyperreflexia*)
- Incontinence of bowel/bladder
- Trouble walking on heels or toes
- None of the above
- Don't Know

7. Are any of the following present in the medical history? (Choose all that apply)

- Cancer that has been treated within the last ten years other than squamous (skwā-mēs) or basal (bā-səl) cell skin cancer
- Back surgery or cervical spine surgery
- Immunosuppression (*hover hint: AIDS, transplant patients, steroids or other immunosuppressant therapy or chronic dialysis*)
- IV drug use
- None of the above
- Don't Know

8. Has a CT or MRI of the cervical spine been performed within the last six months?

- Yes  No  Don't know

9. Has a CT or MRI of the thoracic spine been performed within the last six months?

- Yes  No  Don't know

10. Has a CT or MRI of the lumbar spine been performed within the last six months?

- Yes  No  Don't know

Who will be the responsible contact for additional information or questions, if requested, concerning this request?

Print Name: \_\_\_\_\_

**Additional Information/Comments:**

Check the appropriate box describing you:  Ordering Physician  Facility  Other

**Sign and Date Below:**

Responsible Contact: \_\_\_\_\_

Print Name: \_\_\_\_\_

Sign Name: \_\_\_\_\_

- MD  RN  LPN  PA  NP  Other

Submitter

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