McLaren Flint
FLINT, MICHIGAN 48532

McLaren MRI
RESCHEDULING/RECALL OF PATIENT

Acct. #:_____ MRN #:_____

Patient Name: _____

Exam Ordered: _____ Date: _____

Referring Physician: _____

Reason for recall: _____

Area to be scanned: _____

Series needed to complete exam: _____

_____

_____

_____

Magnet and time needed: _____

Technologist signature: _____Date/Time _____

Radiologist signature: _____ Date/Time _____

No Emergent Findings - Radiologist Initials _____ Date/Time _____

****

Referring Office Contact: _____ Time:_____ Date:_____

MR Staff making contact with: Ref. Physician _____ Patient _____
Initials Initials

MRI Rescheduled _____
Date Time

Follow up notes:

PT.

MR.#/RM.

DR.