For Prior Authorization, please call or fax:
Phone 781.329.0600 • Fax 781.329.1713
If faxing an order, please include:
Demographics • Insurance Card • Clinical Notes

CENTER FOR
DIAGNOSTIC IMAGING®

Chiropractic Referral Form

❍ **Chelmsford:** **P** 978.250.1866 **F** 978.256.9536
❍ **Dedham:** **P** 781.329.0600 **F** 781.329.1713
❍ **Peabody:** **P** 978.818.6272 **F** 978.818.6282
❍ **Haverhill:** **P** 978.469.0400 **F** 978.469.0408
❍ **Woburn:** **P** 781.932.8650 **F** 781.932.8619
❍ **Springfield:** **P** 413.781.9000 **F** 413.781.7988

Appointment Date and Time ❍ DACBR Read ❍ Obtain Authorization ❍ Schedule Patient

Patient Name (as shown on insurance card)	Cell Phone	Home Phone

Patient DOB	Insurance	Insurance ID #

❍ Workers' Comp ❍ Auto	Date of Injury	Authorization #

(REQUIRED) Written Diagnosis/Reason/Symptom for Exam(s). Must include **specific** clinical indications (such as location, context and severity) to support medical necessity for each test.

Is the exam/procedure related to an injury? ❍ No ❍ Yes **If yes,** ❍ Initial, ❍ Subsequent or ❍ Sequela

REPORTING METHOD: ❍ CD w/Report ❍ PT to Carry Films/CD ❍ STAT: Call Report **Report to (Fax/Phone/Address)**
❍ Report Only ❍ Film w/Report ❍ Portal/Web Viewing ❍ STAT: Fax Report

MRI

❍ **Without Contrast** ❍ **With Contrast** ❍ **With/Without Contrast** ❍ **IV Contrast as clinically indicated by radiologist**

NEURO

Brain
- ❍ Brain Volumetric Imaging (NeuroQuant®)

Spine
- ❍ Cervical
- ❍ Thoracic
- ❍ Lumbar

❍ Lumbosacral Plexus (includes piriformis)
❍ Sacrum and Sacroiliac Joints
❍ Sacrum to include Coccyx
❍ Other ______

OTHER

❍ Other ______

MUSCULOSKELETAL

❍ Joint ______
❍ L ❍ R ❍ BIL
❍ Extremity (non-joint) ______
❍ L ❍ R ❍ BIL
❍ Other ______

X-RAY

(DEDHAM & SPRINGFIELD ONLY)

Views: ______

❍ Cervical
❍ Cervical flex/ext
❍ Cervical - Davis w/obliques
❍ Thoracic
❍ Lumbar
- ❍ Standing ❍ Recumbent

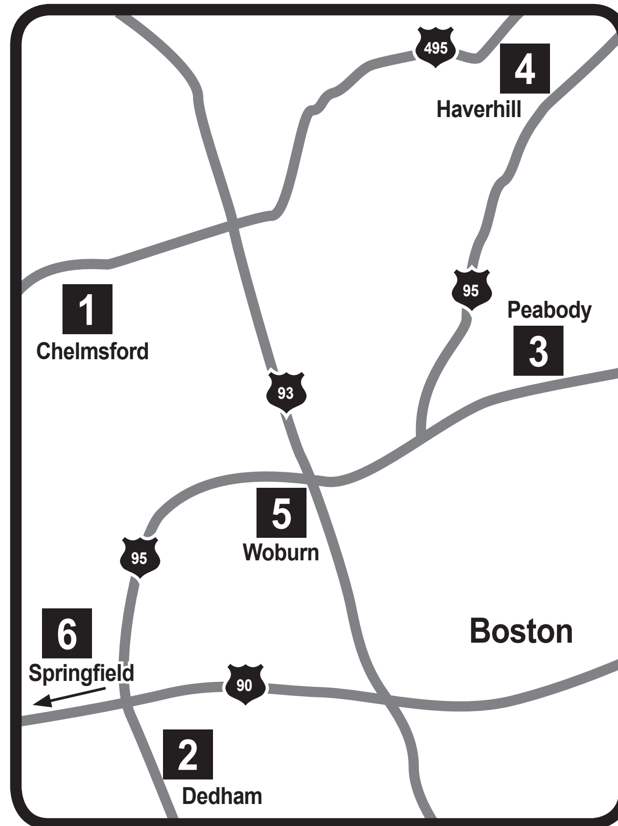
❍ Lumbar w/obliques
❍ Lumbar flex/ext
❍ Pelvis
❍ Ribs ❍ L ❍ R ❍ BIL

❍ Shoulder ❍ L ❍ R ❍ BIL
❍ Elbow ❍ L ❍ R ❍ BIL
❍ Wrist ❍ L ❍ R ❍ BIL
❍ Hand ❍ L ❍ R ❍ BIL
❍ Hip ❍ L ❍ R ❍ BIL
❍ Knee ❍ L ❍ R ❍ BIL
❍ Ankle ❍ L ❍ R ❍ BIL
❍ Foot ❍ L ❍ R ❍ BIL
❍ X-ray to rule out metal
❍ Other ______

Provider Name (Print)	Phone #	Fax#

(REQUIRED) Provider Signature	**(REQUIRED) National Provider #**	Date
Provider signature required. Do not use rubber stamp.		

CENTER FOR
DIAGNOSTIC IMAGING®



#	CENTER	PHONE	FAX	ADDRESS	MRI	OPEN MRI	THERAPEUTIC INJECTIONS	ARTHRO	X-RAY
1	Chelmsford	978.250.1866	978.256.9536	187 Billerica Rd., Chelmsford, MA 01824	●	●			
2	Dedham	781.329.0600	781.329.1713	200 Providence Hwy., Suite 210, Dedham, MA 02026	●	●	●	●	●
3	Peabody[1]	978.818.6272	978.818.6282	One Orthopedics Dr., Peabody, MA 01960	●			●	
4	Haverhill	978.469.0400	978.469.0408	One Park Way, Haverhill, MA 01830	●				
5	Woburn	781.932.8650	781.932.8619	800 W. Cummings Park, Suite 1150, Woburn, MA 01801	●	●			
6	Springfield	413.781.9000	413.781.7988	3640 Main St., Suite 101, Springfield, MA 01107	*MRI, CT, Arthrography, Bone Density (DXA), Ultrasound, X-ray*				

[1]Peabody Imaging North NPI 1760423719/TIN 04-3205435

Magnetic Resonance Procedures

Currently, there are no known biological hazards from MRI; however, since the technique involves strong magnetic fields, certain precautions must be taken. For safety reasons, exclusion from MRI examinations includes patients with: cardiac pacemakers, cardio defibrillators (ICD), cochlear ear implants, insulin pumps, severe renal disease, internal ferromagnetic aneurysm clips in the brain, metallic shrapnel or foreign bodies in or near vital structures (e.g. eyes).

Prior to exam, inform the office if you are/may be pregnant.

Contrast Studies

Patients over 60 years of age require a blood test prior to their contrast study.

A serum creatinine is required for patients if:

1. Diabetic
2. Known renal disease
3. Chemotherapy within the last 6 months
4. Renal transplant patient
5. Previous nephrectomy
6. Hypertension requiring medication