



☐ 1561 W. Fairbanks Avenue
Suite 101
Winter Park FL 32789

☐ 830 Commed Blvd
Suite E
Orange City, FL 32763

☐ 1040 Mason Ave.
Daytona Beach, FL 32117

☐ 769 CR466
Lady Lake, FL 32159
Scheduling Line
Phone: 352-788-4610
Fax: 352-658-0784

☐ 5287 Alhambra Drive
Orlando, FL 32808

Email: mri@sterlingmedgroup.com
Scheduling Line: 386-456-3270
Scheduling Fax: 386-917-1964

Patient Name: _____ Date: _____
DOB: _____ Referring Physician: _____
Patient Phone#: _____ Practice Name: _____
Diagnosis: _____ Practice Address: _____
Insurance: _____ Physician's Phone#: _____
Insurance Provider Claim#: _____ Physician's Fax#: _____
Date of Accident: _____

MRI

☐ Ankle Rt Lt
☐ Branchial Plexus
☐ Brain
☐ Cervical
☐ Elbow Rt Lt
☐ Femur Rt Lt
☐ Fingers Rt Lt
☐ Forearm Rt Lt
☐ Foot Rt Lt
☐ Hand Rt Lt

☐ Hip Rt Lt
☐ Humerus
☐ Knee Rt Lt
☐ Lumbar
☐ Pelvis
☐ Shoulder Rt Lt
☐ Tib/Fib
☐ Toes
☐ Thoracic
☐ Wrist Rt Lt

☐ Other _____

☐ **OPEN MRI** - Winter Park Only

Special Instructions: _____

Please remember to bring picture ID, all pertinent medical records & insurance information with you to your appointment.

I hereby authorize Sterling Medical Group to act on my behalf to obtain any authorizations needed for any diagnostic testing that I order for the above named patient. I hereby certify that the ordered tests above are medically necessary for the diagnosis and treatment of this patient.

Physician Signature: _____ Date: _____