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Please Include: PATIENT INSURANCE, DEMOGRAPHICS and CLINICAL NOTES

ARIA Brain MRI

Patient Name: _____ D.O.B. _____ Date: _____

Cell Phone: _____ Alt Phone: _____ Diagnosis/ICD-10 Code: _____

Gender at Birth: Male/ Female Height: _____ Weight: _____

Diabetes: Y / N **Please Include a list of ALL medications and dosage with order.**

Patient History:

Referring Physician: _____ Physician Phone: _____

Physician Signature: _____ Call Report Phone: _____

Recent relevant imaging (circle all that apply): CT MRI NM PET Other: _____

**please send prior radiology reports and images*

EXAM INFORMATION

Kisluna

- _____ Initial MRI Request Date
- _____ 2nd Treatment MRI Request Date
- _____ 3rd Treatment MRI Request Date
- _____ 4th Treatment MRI Request Date
- _____ 7th Treatment MRI Request Date

Leqembi

- _____ Initial MRI Request Date
- _____ 3rd Treatment MRI Request Date
- _____ 5th Treatment MRI Request Date
- _____ 7th Treatment MRI Request Date
- _____ 14th Treatment MRI Request Date