PHYSICIAN REVIEW FORM

Please have your ordering physician complete this form and include with application.

Physician Name:_____Physician Phone: _____

Physician Address: _____

Physician Email:_____Patient Name: _____

Patient Date of Birth: _____

1. Based on my examination and/or review of medical records, the above-mentioned patient:

   □ Exhibits symptom(s) that may indicate a diagnosis of multiple sclerosis
   OR
   □ Has a diagnosis of multiple sclerosis

2. To help either confirm a diagnosis of MS or evaluate current MS disease progression, the above-mentioned patient requires a:

   □ Cranial (brain) MRI □ C-Spine MRI □ Both Cranial & C-Spine MRIs

3. Conflict of interest disclosure: As the ordering physician, do you have any financial investment in any imaging facilities that you would be referring your patient to?

   □ Yes □ No

   If yes, please provide the facility name and address:

   _____

□ Yes, I hereby certify that the above information provided to MSAA is accurate to the best of my knowledge. I have received the above-mentioned patient's permission to release such statements regarding his or her treatment and/or diagnosis.

Physician Signature:_____Date: _____

If approved, please coordinate with your doctor to have your MRI script faxed to the imaging center that will perform your MRI(s).

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