

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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