

Appointment Date/Time: _____ DOB: _____

PLEASE CALL ORDER IN FOR SAME DAY APPOINTMENTS

Patient Name: _____ Insurance: _____ ID#: _____

Cell Phone: _____ Secondary Ins.: _____ ID#: _____

Home Phone: _____ Authorization: _____

Referring Physician Signature: _____

ICD-10 Code: _____

May Modify Exam at Radiologist's Discretion if Clinically Indicated

Scan as Ordered

STAT

Deliver Disk

Send Disk w/patient

Diagnosis: _____

Print Referring Dr.: _____ Doctor Office Contact: _____

Office Phone #: _____ Office Fax#: _____

Referral Checklist:

- | | |
|---|---|
| <input type="checkbox"/> Physician Information, Clinical Notes, & Signature | <input type="checkbox"/> Diagnosis |
| <input type="checkbox"/> Name | <input type="checkbox"/> ICD-10 Code (if possible) |
| <input type="checkbox"/> DOB | <input type="checkbox"/> Type of Scan |
| <input type="checkbox"/> Phone Number | <input type="checkbox"/> Demographics |
| <input type="checkbox"/> Insurance Company & ID Number | <input type="checkbox"/> Labs (only if you have them) |
| <input type="checkbox"/> Secondary Insurance (if patient has) | |

We will schedule your patient and take care of the PA's once this information is received.

MRI

- | | | |
|---|---|---|
| <input type="checkbox"/> Open MRI (over 350lbs or claustrophobic) | <input type="checkbox"/> Brachial Plexus | <input type="checkbox"/> Lower Leg (no joint) |
| <input type="checkbox"/> High Field MRI | <input type="checkbox"/> Soft Tissue Neck | <input type="checkbox"/> Abdomen (HF only, indicate organ) |
| <input type="checkbox"/> With & Without Contrast | <input type="checkbox"/> TMJ | <input type="checkbox"/> MRCP (HF only) |
| <input type="checkbox"/> Without Contrast | <input type="checkbox"/> Spine | <input type="checkbox"/> Pelvis |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar <input type="checkbox"/> Sacrum | <input type="checkbox"/> Hip(s) <input type="checkbox"/> R <input type="checkbox"/> L |
| <input type="checkbox"/> Pituitary | <input type="checkbox"/> Shoulder <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Femur <input type="checkbox"/> R <input type="checkbox"/> L |
| <input type="checkbox"/> IAC | <input type="checkbox"/> Humerus (no joint) <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Knee <input type="checkbox"/> R <input type="checkbox"/> L |
| <input type="checkbox"/> Orbits | <input type="checkbox"/> Elbow <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Foot <input type="checkbox"/> R <input type="checkbox"/> L |
| <input type="checkbox"/> MRA Brain | <input type="checkbox"/> Wrist <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Ankle <input type="checkbox"/> R <input type="checkbox"/> L |
| <input type="checkbox"/> MRA Neck | <input type="checkbox"/> Hand <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> Other _____ |

CT

*** Labs Needed For IV Contrast IF: (Please fax w/ order if available.)**
 Age 60 & Up Diabetic Renal DX Creatinine: _____

- | | | |
|--|--|---|
| <input type="checkbox"/> Without <input type="checkbox"/> With <input type="checkbox"/> With/Without | <input type="checkbox"/> Abdomen | CT ANGIOGRAPHY |
| <input type="checkbox"/> Draw Labs if Needed | <input type="checkbox"/> Pelvis | <input type="checkbox"/> CTA Runoff |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Kidney Stone Protocol Abd/Pel w-o | <input type="checkbox"/> CTA Abdomen/Pelvis w/ 3D Reformat |
| <input type="checkbox"/> Internal Auditory Canals | <input type="checkbox"/> Hip <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> CTA Brain |
| <input type="checkbox"/> Orbits | <input type="checkbox"/> Extremity _____ | <input type="checkbox"/> CTA Neck w/ 3D Reformat |
| <input type="checkbox"/> Sinuses | | <input type="checkbox"/> CTA Abdomen |
| <input type="checkbox"/> Mandible/Facial Bones | | <input type="checkbox"/> CTA Chest (P.E. Protocol) w/ 3D Reformat |
| <input type="checkbox"/> Temporal Bones | <input type="checkbox"/> Hand | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Neck (Soft Tissue) | <input type="checkbox"/> Wrist | |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Ankle | |
| <input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> Thoracic | <input type="checkbox"/> Foot | |
| <input type="checkbox"/> Abdomen / Pelvis | | |

PLEASE FAX COPY OF PATIENT DEMOGRAPHICS, CLINICAL NOTES, & INSURANCE CARDS



Touchstone

MEDICAL IMAGING

If you have had previous diagnostic studies of the body part being evaluated, please bring those films and reports, or request they be sent to the Center. These studies or reports are very helpful to the Radiologist interpreting your exam.

MAGNETIC RESONANCE IMAGING (MRI)

Please let your MRI Technologist know if you have a pacemaker, surgical clips, a prosthesis, previous surgery, metal implants or any other metal objects in your body. Some implants (e.g. a pacemaker) may be affected by a MRI examination. Clinic personnel will determine whether or not you should proceed with the MR examination.

COMPUTED TOMOGRAPHY (CT)

Abdomen or Abdomen and Pelvis

You have the option of contacting our office to obtain your contrast (2% barium sulfate) one-two days prior to your exam.

Eat a light dinner the evening before your exam and have nothing to eat or drink 4-6 hours prior to your exam. You may take your regular medications with a small amount of water.

Oral Contrast Directions

ABDOMEN & PELVIS: On the day of your exam, drink one bottle (450ml) of your oral contrast two hours before your exam. Drink the second bottle (450ml) one hour before your exam. Nothing to eat or drink 4-6 hours prior to your exam.

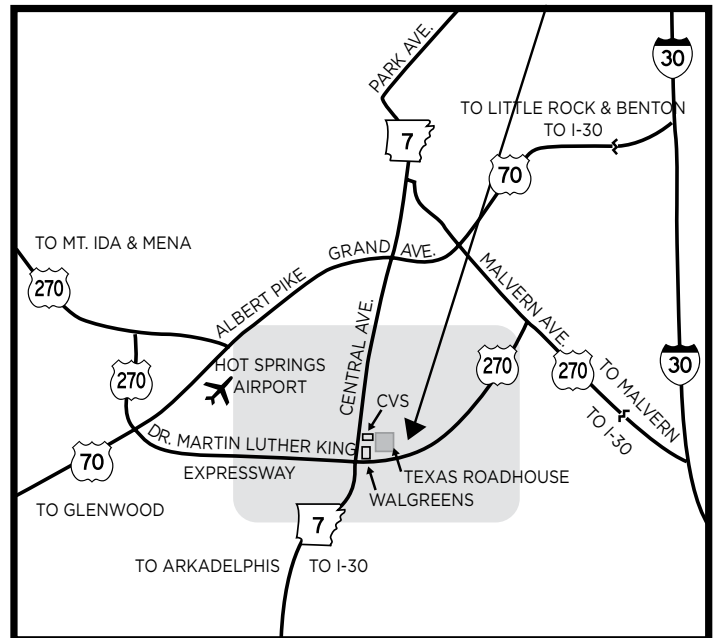
Tell the CT or MRI Technologist:

- If you are pregnant or breast feeding
- If you have had a barium enema or UGI within the last two weeks
- If you have had brain, heart, ear, eye or other surgeries
- If you have had an IVP within 48 hours

Most Insurances Accepted Including:

- | | |
|----------------------------|---------------------|
| • Aetna® | • Medicaid |
| • Ambetter® | • Medicare |
| • Amco | • QualChoice® |
| • AR Kids | • TRICARE® |
| • Blue Cross® Blue Shield® | • UnitedHealthcare® |
| • Cigna® | • Wellcare® |
| • First Health® | • Workers Comp |

If your insurance is not listed, please call our office for further details.



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