# Scheduling Form

Scheduled by________________________________________ Date__________

Scheduled date________________ Time_____________ ACCT#_______________ SCAN ID#_______________

Date or time preference? ❒ Yes ❒ No ____________________________________________________________

Patient name ____________________________________________________________
(last) (first) (M.I.)

Patient phone____________________________________________________________
(daytime) (evening)

Body part ____________________________________________________________ Contrast/Gadolinium: ❒ Yes ❒ No

Diagnosis/clinical data ____________________________________________________________

____________________________________________________________

Insurance type: ❒ Auto ❒ Health ❒ W/C ❒ Litigation

Insurance company ____________________________________________________________

Claustrophobia: ❒ Yes ❒ No (❒ Mild ❒ Moderate (short of breath in small places) ❒ Severe)

Ordering Physician________________________________________ Specialty ___________________________________

Person scheduling_________________________________ PH#______________ FAX# ___________________________

## Precertification Information

Sex_______

Weight_________ Height__________

DOB______________________ SS#________________________________

Insurance policy______________________ Insured____________________

Claim #_________________________________________________ Date of accident____________________

Insurance company phone # ____________________________________________________________

Precertification required? ❒ Yes ❒ No Pre-Cert # ____________________________________________

Other insurance information ____________________________________________________________

____________________________________________________________

Previous films: ❒ MRI ❒ CT ❒ X-Ray ❒ Other____________________________________________
(Have patient bring for comparison)

Previous surgery on this area? ❒ Yes ❒ No If so, when? ______________________________________

Contrast allergy? ❒ Yes ❒ No Other contraindications _____________________________________

Other doctors treating patient for this condition? ❒ Yes ❒ No

Name(s)____________________________________________________________

PH#_____________________________________ FAX#______________________________________

Address ____________________________________________________________

PCP___________________________________________ PH#______________ FAX#____________________

**NOTES**

**Technologist Comments**
Pt. injected w_____cc Gd-DTPA
Meds given_________________
Time_________ Initials______
Allergies__________________
Outside films ❒ Yes ❒ No

To referring physicians/office staff: Complete area shaded in gray only, then FAX to (719) 544-7599.

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