IMAGING OUTPATIENT PROCEDURE REQUEST FORM

Instructions: Complete this form, sign it and fax it to the department (numbers above) or give to your patient to bring to their appointment.

Patient's Name: _____________________________ Date of Service: ____ /____ / _____

   Last                        First                        M.I.

Time of Exam: _______________

Date of Birth: ____ /____ / _____

Home Phone: _______________

Procedure: __________________________________________________________________________________

History:

Personal or family medical history related to the procedure

Symptoms & Chief Complaint:

Personal or family medical history to include allergies related to the procedure

Any specific signs, symptoms or complaints related to this procedure; not “rule-out” or “routine”

What questions do you want answered? __________________________________________________________________________________

Date of Injury

Is this for Workmens Comp?

________________________________________________________________________

Physician Signature: _______________________________________________ __________________

Required Date

Print Name: _____________________________________________________________

Office Phone: ___________________________ Office Fax Number: _________________________

Copy of Report To: ________________________________________________________

☐ Patient to return to my office  ☐ Films and wet read  ☐ Wet read only
☐ Films only  ☐ Patient may leave  ☐ Other ______________________________

Record Decision Support Information?

- Decision Support Vendor: ____________________________
- Decision Support Adherence: ________________________
- Decision Support Session ID: ________________________
- Decision Support Score: ______________________________

ITEM #19018 (Rev. 12/20)