HAWAIʻI PACIFIC HEALTH | KAPIʻOLANI MEDICAL CENTER FOR WOMEN & CHILDREN

Diagnostic Imaging Department
Sedation Intake Form

Date of request: _____ Time: _____
Information received from: _____ Phone: _____ Fax: _____

Patient: _____ Age: _____ DOB: _____
Address: _____
Weight: _____ Sex: _____ Resides with: _____
Parents/Legal Guardian's name: ___ _____
Best time to contact: _____ Hm: _____ Cell: _____
Special needs (translator, social worker, etc): _____

- ☐ EEG _____ (must also complete EEG order form)
- ☐ MRI _____ (must also complete MRI order form)
- ☐ MRA _____
- ☐ CT _____ (must also complete CT order form)
- ☐ ECHO _____
- ☐ U/S _____
- ☐ NUCLEAR MEDICINE _____
- ☐ OTHER:_____

cc Results to: _____ Fax #: _____

Indication(s) for test(s): _____
Indication for sedation: _____
Previous sedation experience: _____

Physician signature: _____

Primary Insurance: _____ ID# _____ Subscriber: _____
Secondary Insurance: _____ ID# _____ Subscriber: _____
Pre-authorization # for procedure: _____
*__Must be provided before we can schedule an appointment.__

Patient's PCP: _____ Phone #: _____ Fax #: _____

Diagnostic Imaging Department use only

OR Scheduler's name: _____ Appointment confirmed date/time: _____
ORSOS case #: _____ Appointment date and time: _____
M.D. office notified of appointment date: _____