

Please fill out the information in the box below and all to the right:



Please Fax to: 315-792-9698
Or Call 315-792-1985

*Reserve Stat Appts by phone only.

Provider Contact Name: _____

Inform Office of Appt. Date/time by:

Phone or Fax

Service Location Request: Yes No

If yes, please circle:

Open: BP Ilion
Closed: SDMG St.Lukes St.E's

Interpreter needed?: Yes No

Language: _____

Provider/ Patient Screening:

Please check:

- Surgery to the area of scan?
- Pacemaker or Defib.?
- Any implants at all?
- Metal in the body at all?
- Surgeries in the last 6 wks?
- Claustrophobic?
- Allergy to contrast
Type: _____

If receiving contrast:

Contrast Protocol Screening:

Please check:

- Hypertension?
- Diabetes?
- Age >60yrs?
- Kidney or Liver disease?
- Is the pt undergoing Dialysis?

* Labwork is required in the last 45 days, if any of the above are checked.

***Renal Function Labwork:**

Date: _____

Creatinine: _____ GFR: _____

Please attach labwork results when available.

Thank you for your Referral!
"For MRI, it's CMI!"

For CMI	Appointment Date:	Time:	CMI Site:
Office use:	_____	_____	_____

P A T I E N T I N F O	DOB: _____
	Last name: _____ First name: _____
	Male or Female _____ Phone (home): _____ Work/Cell: _____
	Primary Insurance: _____ ID#: _____
	Auth#: _____
	Secondary Insurance: _____ ID#: _____
	Auth#: _____
	Please circle if applicable: W/C No Fault Self Pay

E X A M I N F O	Exam(s) requested: _____ Contrast: Y or N
	Present diagnosis and/or complaint: _____
	Prior Exams: please check <input type="checkbox"/> MRI <input type="checkbox"/> Bone scan Facility: _____ <input type="checkbox"/> CT <input type="checkbox"/> US Date: _____ <input type="checkbox"/> X-ray <input type="checkbox"/> Mammo Report attached: Y or N <input type="checkbox"/> Other _____

P R O V I D E R	Physician Information:
	Referring Physician: _____
	Address: _____
	Phone: _____ Fax: _____
	C.C.: _____
	Physician Signature and date: _____

