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

Cooperative Magnetic Imaging

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
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:*_____

See back if patient has pacemaker.

If receiving contrast:
Contrast Protocol Screening:
Please check:

- ( ) **Hypertension?**
- ( ) **Diabetes?**
- ( ) **Age 60 yrs or older?**
- ( ) **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!"

Version 1.4 08/14

For CMI **Appointment Date:** **Time:** **CMI Site:**

Office use: _____ _____ _____

PATIENT INFO

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***

EXAM INFO

Exam(s) requested:	**Contrast: Y or N**
Present diagnosis and/or complaint:	

Prior Exams: *please check*

( ) MRI ( ) Bone scan Facility:_____
( ) CT ( ) US Date:_____
( ) X-ray ( ) Mammo Report attached: Y or N
( ) Other_____

PROVIDER

Physician Information:

Referring Physician: _____

Address: _____

Phone: _____ **Fax:** _____

C.C.: _____

Physician Signature and date: _____