

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

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!"

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#: _____
E X A M	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	<b>Physician Information:</b>
	Referring Physician: _____
	Address: _____
	Phone: _____ Fax: _____
	C.C.: _____
	Physician Signature and date: _____