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

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!"

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

Reserve Stat Appts by phone only.

For CMI Office use: **Appointment Date:** _______________ **Time:** _______________ **CMI Site:** _______________

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: ____