Office 785.856.0224
Fax 785.330.5652

4930 Overland Drive
Lawrence, KS 66049

medimageks.com

Advanced Medical Imaging

PROVIDER REFERRAL FORM

Patient Name: _____ **Date of Birth** _____

Home Phone: _____ **Business Phone:** _____

CLINICAL INDICATIONS/DIAGNOSIS:_____ **ICD 10:**_____

Insurance Type: _____ **ID Number**:_____

CT SCAN

(BUN & Creatinine level needed for CT Contrast pts. 60 & older, diabetic pts., & pts. with a history of renal disease)

☐ With ☐ Without ☐ With & Without

☐ Head
☐ Pituitary
☐ Internal Auditory Canals
☐ Sinuses (specify)
☐ LTD limited ☐ Pediatric Protocol
☐ Comp ☐ Landmark Protocol
☐ Neck
☐ Chest ☐ Pulmonary Nodule follow-up
☐ Abdomen ☐ CTA _____
☐ Pelvis ☐ Chest/Pulmonary Embolism Protocol
☐ Urogram
☐ Renal Stone Protocol
☐ CT Enterography
Extremity (specify) _____
☐ Spine
☐ Cervical
☐ Thoracic
☐ Lumber
☐ Cardiac Scoring
☐ Lung Scan/Screening
☐ Other _____

MRI EXAMS

☐ With ☐ Without ☐ With & Without

☐ Head
☐ Orbits
☐ Pituitary
☐ Internal Auditory Canals
☐ Soft Tissue Neck
☐ Abdomen
☐ Magnetic Resonance Cholangiopancreatography
☐ Pelvis
☐ Lower Extremities
☐ Other_____

MR/SPINE

☐ With ☐ Without ☐ With & Without

☐ Cervical
☐ Thoracic
☐ Lumbar/Sacral
☐ Sacrum/Coccyx

MR ANGIOGRAPHY

☐ With ☐ Without ☐ With & Without

☐ MRA Head/Circle of Willis
☐ MRA Carotids
☐ MRA Renal Arteries
☐ MRA Lower Extremity
☐ MRA Other _____

MRI MUSCULOSKELETHAL

☐ With ☐ Without ☐ With & Without

☐ Shoulder Left/Right
☐ Scapula Left/Right
☐ Elbow Left/Right
☐ Wrist Left/Right
☐ Knee Left/Right
☐ Ankle Left/Right
☐ Foot Left/Right
☐ Other_____

PRECERTIFICATION

Referring Office to pre-cert

Pre Cert#_____

Effective Dates:_____

CALL REPORT ☐ **YES** ☐ **NO**

Office Name _____
Number _____
Fax _____

GENERAL INFORMATION:

- If you might be pregnant, please call our office before your scheduled appointment.
- If you have had asthma or any previous reaction to X-ray contrast agents, please call this office at least 2-3 days prior to your scheduled appointment.
- If you have a question regarding your exam or the preparation for the exam, please do not hesitate to call us. Technologists will be available should you need them.
- If for any reason you are unable to keep your appointment you must call to notify and reschedule.

PATIENT INSTRUCTIONS:

CT CONTRAST STUDY: Nothing to eat or drink 4 hours prior to exam time.
CT NO IV CONTRAST STUDY: No restrictions.
CT ABD: Arrive one hour prior to exam time.
CT PELVIS OR CT ABO/PELVIS: Arrive two hours prior to exam time.
MRI: You do not need to discontinue any medication and there are no dietary restrictions for most MRI studies. Certain individuals with cardiac pacemakers, brain aneurysm clips, a history of metallic fragments in an eye, or certain other implanted devices may not be candidates for MRI due to safety concerns. Please inform the technologist if you believe any of these conditions apply to you.

Signature of Referring Physician:

_____Date_____

Name:_____

Today's Date: _____ **Appointment Time & Date:** _____ **Call Patient to Schedule Exam**