NORTHEAST IMAGING

1703 Lamy Ln • Monroe, LA 71201
Tax ID: 82-4455167
www.capitolimagingcenters.com

PATIENT SCHEDULING REFERRAL FORM

Phone: 318-570-4985 • Fax: 318-450-4040

Appointment Date: _____

Appointment Time: _____

Date Ordered/Faxed: _____

f

Patient Name _____ D.O.B. _____ SS#: _____

Home Phone: _____ Work Phone: _____ Cell #: _____

Patient Insurance: _____ Policy #: _____ Group #: _____

Physician Name Printed: _____ Physician Signature: _____

Physician Phone: _____ Physician Fax: _____

Office Contact: _____ NPI#: _____ UPIN# _____

Diagnosis: _____ DX/ICD-10 Code: _____

Previous Comparison Study: ❑ Yes ❑ No Facility Name _____

MRI

CONTRAST

❑ **Without** ❑ **W/WO**

BUN/CREAT needed on all contrast studies, if diabetic or age 60 and older.

STUDY

- ❑ Head/brain
  - ❑ Pituitary ❑ IACs ❑ Orbits
- ❑ Soft Tissue Neck
- ❑ Cervical Spine
- ❑ Thoracic Spine
- ❑ Lumbar Spine
- ❑ Pelvis
- ❑ Knee: ❑ Left ❑ Right
- ❑ Shoulder: ❑ Left ❑ Right
- ❑ MRA ❑ Head ❑ Neck ❑ Renal
- ❑ MRV Head
- ❑ Other (specify) _____

Special Instructions:

CT

CONTRAST

❑ **Without** ❑ **With** ❑ **W/WO**

BUN/CREAT needed on all contrast studies, if diabetic or age 60 and older.

STUDY

- ❑ Head/brain
- ❑ Temporal Bones
- ❑ Orbits/Facial Bones
- ❑ Sinuses
- ❑ Soft Tissue Neck
- ❑ Chest
- ❑ Abdomen
- ❑ Pelvis
- ❑ Cervical Spine
- ❑ Thoracic Spine
- ❑ Lumbar Spine
- ❑ Other (specify) _____

Special Instructions:

XRay

- ❑ Orbits (MRI clearance)
- ❑ Skull
- ❑ Sinuses
- ❑ Chest
- ❑ Spine ❑ C ❑ T ❑ L
- ❑ Ribs
- ❑ Shoulder ❑ Left ❑ Right
- ❑ Forearm ❑ Left ❑ Right
- ❑ Elbow ❑ Left ❑ Right
- ❑ Wrist ❑ Left ❑ Right
- ❑ Hand ❑ Left ❑ Right
- ❑ Finger (specify) _____
- ❑ Abdomen (KUB)
- ❑ Pelvis
- ❑ Sacrum/coccyx
- ❑ Hip ❑ Left ❑ Right
- ❑ Knee ❑ Left ❑ Right
- ❑ Lower Leg ❑ Left ❑ Right
- ❑ Ankle ❑ Left ❑ Right
- ❑ Foot ❑ Left ❑ Right
- ❑ Toes (specify) _____
- ❑ Other (specify) _____

❑ **Call Report** ❑ **Give Copy of CD to Patient** ❑ **CD**