



REFERRAL / SCHEDULE BY FAX FORM

Scheduling: (F) 256-734-6296 • (P) 256-734-8175

Patient Name _____ Tel: _____ Date: _____

Patient Insurance _____ Policy # _____ Group # _____ D.O.B. _____

Workers Comp _____ Atty _____ Authorization # _____

Diagnosis – Written and/or ICD-10 Code (Required) _____

Physician's Signature (Required) _____ Physician Name (please print) _____

Call Preliminary Reading Tel # _____ After Hours Tel # _____

Address _____ Tel: _____ Fax: _____

MRI			CT			
	w/o	w & w/o	w/o	w	w & w/o	
Head			<input type="checkbox"/> Abdomen/Pelvis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Brain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Abdomen/Pelvis (w/contrast only)			
<input type="checkbox"/> IAC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Orbit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pituitary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest (w/contrast only)			
<input type="checkbox"/> Soft Tissue Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Facial Bones (w/o only)			
Musculoskeletal			<input type="checkbox"/> Temporal Bones (w/o only)			
<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Humerus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Pelvis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sinus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Forearm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Soft T-Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Wrist	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal			
<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Humerus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Femur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tibula/Fibula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Forearm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ankle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spine			<input type="checkbox"/> Femur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cervical Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Tibula/Fibula	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Thoracic Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Ankle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Body			<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Brachial Plexus	<input type="checkbox"/>	<input type="checkbox"/>	Spine			
<input type="checkbox"/> Pelvis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> C Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abdomen - Liver	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> T Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Abdomen - Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> L Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Lung Screen			
_____			<input type="checkbox"/> 3D Reconstruction			
_____			<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check here if your patient is to take a CD with them

Check here to have CD delivered via courier

Appointment Location: 1705 Main Avenue SW #C • Cullman AL 35055

Patient Work Telephone: _____ Patient Cell: _____

Appointment Date _____ Time _____ Today's Date _____ Initials _____

ABOUT YOUR EXAM

MRI

Please contact Heritage Diagnostic Center at 256-734-8175 if you are pregnant.

Please contact us if you have a pacemaker.

No eye make-up. No pins or ornaments in your hair. No jewelry. No metal on clothing.

Please remove any medication patch(es) and metal dentures.

MRI can be performed 6-8 weeks from post operative surgery.

CT

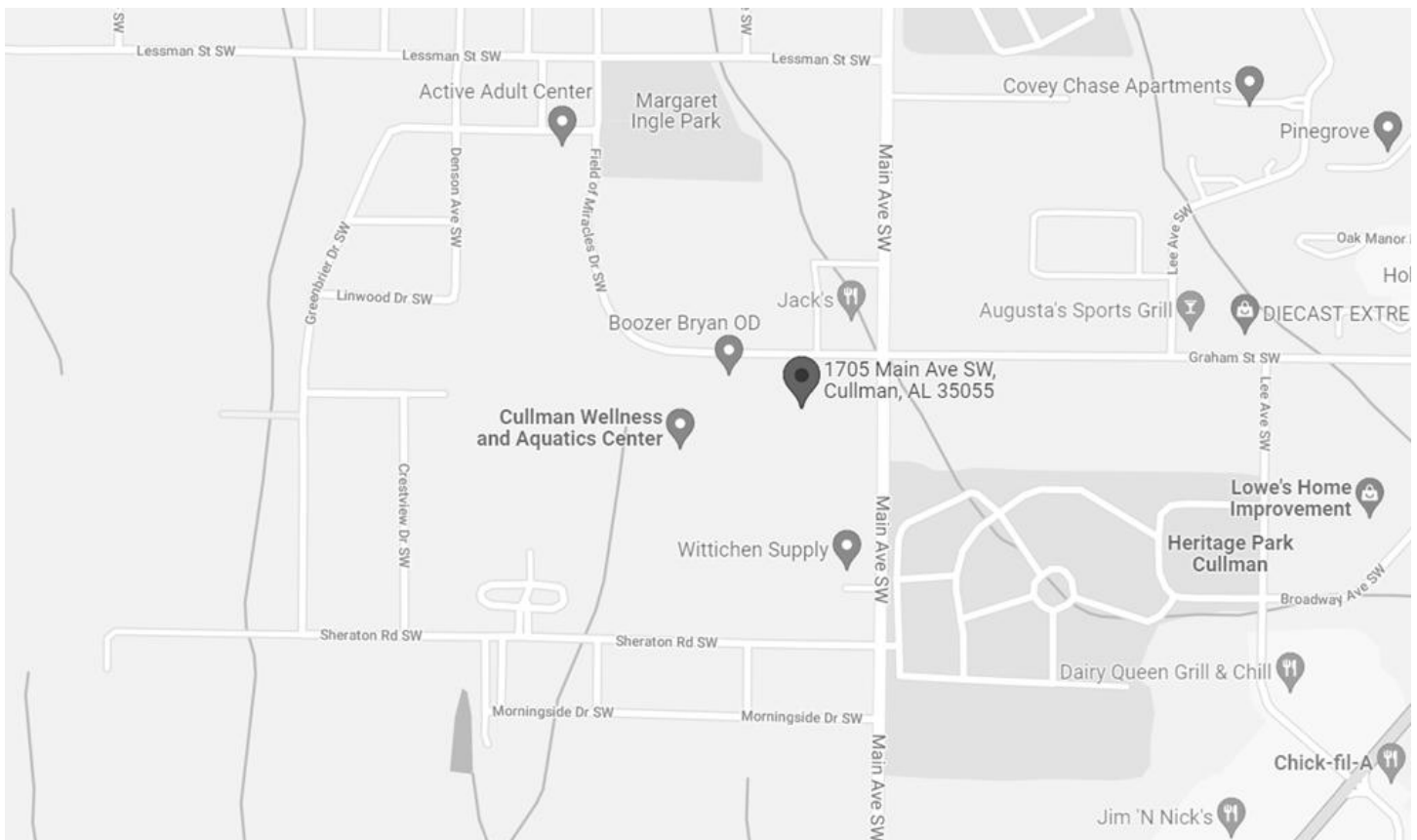
Please contact Heritage Diagnostic Center at 256-734-8175 if you are pregnant.

No pins or ornaments in your hair. No jewelry. No metal on clothing.

If your CT scan is ordered with the use of contrast, you should fast for 6 hours prior to the exam.

Please contact us if you have an allergy to shell fish or iodine.

For more detailed information on all of our exams, please visit www.capitolimagingervices.com



1705 Main Avenue SW #C • Cullman AL 35055

Heritage Diagnostic Center is located near the corner of Main Avenue Southwest and Field of Miracles Drive Southwest. Our center is approximately 1/2 mile north of Heritage Park Cullman and next to Pediatric Dental Associates of Cullman.