



REQUIRED

Please Print

Patient's FULL LEGAL Name: _____ **DOB:** _____ **Sex:** M F
Parent/Guardian's Name: _____ **Phone:** _____ **Cell/Work:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Guarantor Name: _____ **Guarantor DOB:** _____ **Guarantor Sex:** M F
Guarantor Phone: _____ **Relationship to Patient:** _____
Insurance/Medicaid Plan: _____ **Policy & Group #:** _____
Authorization #: _____

DIAGNOSIS:

REQUIRED

ICD-9: _____ **ICD-9 Description:** _____

Ordering Physician's Signature (REQUIRED)

Ordering Practice & Address:

Print MD Name: _____
Date Signed (REQUIRED): _____

Office Phone: _____
Office Contact: _____
Office Fax: _____
Office E-mail: _____

PCP Name: _____
PCP Fax: _____

MRI & CT

Sedation Questionnaire for MRI or CT

Sedation Based on Child's Age Developmental Delay, Special Need
 General Anesthesia (Referring MD should also consult directly with Anesthesiologist)

1) History of apnea or obstructive breathing (ie snoring)? No Yes
 2) Previous complication w ith sedation? No Yes
 3) Less than 6 months old? No Yes

MRI & MRA/MRV Head/Neck		MRI Spine		CT: Head, Face, Neck, Sinus, 3D, Spine	
MRI Epilepsy Surgery Protocol	70551	MRI Spine Cervical w/o	72141	CT Head w/o contrast	70450
MRI Brain w/o	70551	MRI Spine Cervical w ith	72142	CT Head w ith contrast	70460
MRI Brain w ith	70552	MRI Spine Cervical w ith & w/o	72156	CT Head w ith & w/o contrast	70470
MRI Brain w ith & w/o	70553	MRI Spine Thoracic w/o	72146	CT Angiography Head	70496
Brain w/o <input type="checkbox"/> MRA <input type="checkbox"/> MRV	70544	MRI Spine Thoracic w ith	72147	CT Orbit/Sella/Ear w/o contrast	70480
Brain w ith <input type="checkbox"/> MRA <input type="checkbox"/> MRV	70545	MRI Spine Thoracic w ith & w/o	72157	CT Orbit/Sella/Ear w ith contrast	70481
Brain w ith & w/o <input type="checkbox"/> MRA <input type="checkbox"/> MRV	70546	MRI Spine Lumbar w/o	72148	CT Maxillofacial/Sinus w/o contrast	70486
MRI w/o <input type="checkbox"/> Orbit <input type="checkbox"/> Face <input type="checkbox"/> Neck	70540	MRI Spine Lumbar w ith	70549	CT Maxillofacial w ith contrast	70487
MRI w ith <input type="checkbox"/> Orbit <input type="checkbox"/> Face <input type="checkbox"/> Neck	70542	MRI Spine Lumbar w ith & w/o	72158	CT Sinus Limited (Egleston only)	76380
MRI w ith & w/o <input type="checkbox"/> Orbit <input type="checkbox"/> Face <input type="checkbox"/> Neck	70543	Complete Spine w/o	72141,72146,72148	CT Neck w ith contrast	70491
Neck w/o <input type="checkbox"/> MRA <input type="checkbox"/> MRV	70547	Complete Spine w ith	72142,72147,72149	CT Angiography Neck	70498
Neck w ith <input type="checkbox"/> MRA <input type="checkbox"/> MRV	70548	Complete Spine w ith & w/o	72156,72157,72158	CT Cervical Spine w/o contrast	72125
				CT Thoracic Spine w/o contrast	72128
				CT Lumbar Spine w/o contrast	72131
				3D Rendering/Equipment Console	76376

CLINICAL INDICATIONS (check all that apply)

Trauma <input type="checkbox"/> Y <input type="checkbox"/> N	Physical Exam/Symptoms:
Medical Justification/Reason for Exam/History:	<input type="checkbox"/> Headache <input type="checkbox"/> Tingling <input type="checkbox"/> Dizziness <input type="checkbox"/> Numbness <input type="checkbox"/> Seizure <input type="checkbox"/> Auto-Immune Disease <input type="checkbox"/> Gait Abnormality <input type="checkbox"/> History of Cancer <input type="checkbox"/> Visual Changes <input type="checkbox"/> Mass in _____ (location) <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Aneurysm <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Back Pain <input type="checkbox"/> Tinnitus <input type="checkbox"/> Loss of Bladder/Bowel Control
If Headaches, How long? _____ Weeks	Other indications not listed above:
Date of New Onset of Symptoms:	

MEDICATIONS:

Name: _____	Date Started: _____	Currently Taking: <input type="checkbox"/> Y <input type="checkbox"/> N
Name: _____	Date Started: _____	Currently Taking: <input type="checkbox"/> Y <input type="checkbox"/> N
Name: _____	Date Started: _____	Currently Taking: <input type="checkbox"/> Y <input type="checkbox"/> N

Date/Time Req.: _____ Stat Call Report: <input type="checkbox"/> Yes - Phone: Image: <input type="checkbox"/> CD <input type="checkbox"/> Film <input type="checkbox"/> None Foster Child: <input type="checkbox"/> Yes Contact: _____	Notes/Comments/Additional Exams:
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