Schedule at:

◯ Virginia Beach
4668 Pembroke Blvd., Suite 117
Virginia Beach, VA 23455

◯ Chesapeake
1554 River Birch Run North
Chesapeake, VA 23320

MRI·CT DIAGNOSTICS

MRI & CT DIAGNOSTICS
Scheduling and Authorization by Fax
Scheduling Fax (757) 671-1152
(757) 671-1144 • 1-800-486-9886
Scheduling Phone (757) 965-4141

◯ **Schedule Appointment** ◯ **Obtain Authorization** **Date:** _____

PATIENT INFORMATION

PATIENT INFORMATION

Patient Name: LAST * FIRST * INITIAL

Phone: * HOME WORK CELL/PAGER

Social Security Number: * DOB: * Sex: Weight:

Preferred time for appointment: ◯ First Available ◯ Preferred Date / Time:

PHYSICIAN INFORMATION

PHYSICIAN INFO

Referring Physician: * Check Which Location:

Office Contact: Phone: Fax:

CHECK WHICH EXAM SHOULD BE SCHEDULED:

EXAM DETAILS

*( ) MRI ( ) CT ( ) CT w/3D Reconstruction ( ) Arthrogram ( ) Ultrasound ( ) PVL ( ) X-Ray

Area to be examined (please be specific, if contrast is needed please state with and without contrast): * ◯ Routine (no contrast requested) ◯ With and without contrast

* Reason for exam/Pertinent clinical findings:

* Rule out:

* Special requests:

If contrast is being given
Has patient had a BUN or Creatinine test done in the past 6 weeks?
◯ Yes ◯ No If yes, fax results to 671-1152.

* Physician Signature

* Follow up appointment with referring physician: Date _____ Time _____ ◯ am ◯ pm

CLINICAL HISTORY

CLINICAL HISTORY

Check what applies:

Clinical History Needed for Authorization Purposes

Injury: ◯ Yes ◯ No If yes, DOI: _____ What kind (MVA, Sports, W/C): _____

- ◯ X-rays (Please send with patient)
- ◯ Ultrasound
- ◯ Home Exercises
- ◯ Work Restrictions
  If yes, how long: _____
- ◯ Modified Home Activity
- ◯ ICD _____

- ◯ Anti-inflammatory Medicine
- ◯ Pain Medication, specify: _____
- ◯ Antibiotics, specify: _____
- ◯ Steroid Injections–How many times: _____
- ◯ PT–How long did patient have PT: _____
- ◯ Brace/Crutches ◯ Wheelchair ◯ Walker

AUTHORIZATION INFORMATION

AUTHORIZATION

Insurance Plan: * ID Number: Group Number:

WC: Claim Number: DOI: Contact: Phone:

CONFIRMATION

CONFIRMATION

Exam Scheduled: Appt. Date: Time: am pm

Patient notified? ◯ Yes ◯ No Location: ___ Virginia Beach ___ Chesapeake Completed by: Date:

* **Information that needs to be completed**