DERRY IMAGING

603.537.1363 Option 3 Fax: (603) 537-3046

Referring Physician: _____ NPI #: _____

Physician Phone: _____ Fax: _____

Pratice Name: _____ Physician Address: _____

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Cell Phone: _____ Home or Work Phone: _____

Email: _____

INSURANCE INFORMATION

Insurance Carrier: _____ Group/Policy: _____

Policy Holder/DOB: _____ Precert#/Exp Date: _____

Name of Authorization Rep: _____

SCAN INFORMATION

EXAM: □ **MRI** □ **MRA** □ **CT** □ **CTA** **CPT Code/Exam:** _____

Area to be scanned: _____ Prior Surgery to areas: ☐ YES ☐ NO

PRIOR STUDIES WHEN: _____

WHERE: _____

Primary Diagnosis: _____

_____

_____

Signs & Symptoms (ICD-10): _____

(A "rule out" diagnosis may accompany a diagnosis for signs and symptoms but is not acceptable by itself)

If CONTRAST is required: Patients who are over 60, diabetic, or have high blood pressure labs (bun/creat) are required and must be done within 30 days of exam.

WARNING!! AN MRI CANNOT BE PERFORMED IF A PATIENT HAS ANY OF THE FOLLOWING:

Pacemaker or Pacemaker Wires – Defibrillator Device – Cochlear Implant – Small Bowel Endoscopy Capsule

Check if applicable:

☐ Metal in body including eyes ☐ Prior contrast reaction ☐ Claustrophobic ☐ Weighing over 300 lbs.

PHYSICIAN'S SIGNATURE: _____ DATE: _____