2356 N. 400 E. Bldg B, Ste. #103 Tooele, Utah
Phone (435)882-1674 Fax (435)882-1822

Referring Physician:_________________________________ Phone: ____________ Fax:_____________

Date/Time of Exam _________________________________ NPI: ______________

Patient Name (Last, First, M.I.) : ____ DOB: _____________

Address: _________________________________ City/State ___________________ Zip ________

Phone #'s Home: _____________________ Mobile: ________________________

Male □ **Female** □ **If minor, Guardian's name**: ____

Insurance Information:

Primary Insurance: ___________________________ Secondary Insurance: _________________________

Primary Insurance ID#: _______________________ Secondary Insurance ID #: ______________________

Pre-Authorization Required: Yes No Pre-Authorization #: ______________________

***If workers comp**, DOI: __________________ Employer: ____________________

PLEASE REMEMBER TO SEND PATIENT WITH THEIR REFFERAL
OR FAX TO OUR OFFICE PRIOR TO EXAM

CT Scan__________ **MRI Scan**__________ **Ultrasound**__________ **X-Ray**__________

_____ w/o contrast _____ w/ contrast _____w/ contrast as needed

Does Patient have the following?			Creatinine/Date______________					
Pacemaker	Yes	No	Renal Disease	Yes	No	Prior Surgery	Yes	No
Brain Aneurysm Clip	Yes	No	Iodine Allergy	Yes	No	Type ____________________________		
Implanted Electrical Devices	Yes	No	Diabetic	Yes	No	Prior Relevant Imaging	Yes	No
Metal Foreign Body in Eye	Yes	No	Dialysis	Yes	No	Date _______ Where _________________		

Procedure / Referral Information:

Type of Scan: ____

Reason for Scan /Diagnosis/ICD9:____

Special Instructions: ____

Physician Signature: ____

PLEASE NOTE: WE CANNOT PERFORM CT/MRI/US/X-Ray WITHOUT PHYSICIAN SIGNATURE.