

APPOINTMENT LOCATION:

- Bristol – Hartford HealthCare HealthCenter – Imaging
- Cheshire Imaging
- MidState Medical Center – Radiology
- MRI of New Britain

- Mystic Imaging
- Norwich Imaging
- Vernon Imaging
- Wallingford Imaging
- West Hartford Imaging
- Whitney Imaging

- The Hospital of Central Connecticut – Bradley Memorial Campus – Imaging
- The Hospital of Central Connecticut – New Britain General Campus – Imaging
- The Hospital of Central Connecticut – Plainville – Imaging

- Backus Hospital – Imaging
- Backus Outpatient Care Center
- Colchester – Hartford HealthCare HealthCenter – Imaging
- Plainfield Emergency Care Center

PATIENT INFORMATION

Last Name	First Name	Date of Birth	Weight	Height
Address		Home Phone	Other Phone	
Primary Insurance (Company)	Policy #	Group #	Authorization #	
Secondary Insurance (Company)	Policy #	Group #	Authorization #	

MEDICAL HISTORY

Reason for Imaging Services – Symptoms:

<input type="checkbox"/> STAT	<input type="checkbox"/> Call ordering provider with results to phone #: _____ <input type="checkbox"/> Date of Injury: _____ <input type="checkbox"/> Prior Surgery? When?: _____	Location: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Lower quadrant <input type="checkbox"/> Upper quadrant	<input type="checkbox"/> Call patient to schedule <input type="checkbox"/> Patient to take CD
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TYPE OF IMAGING REQUESTED

<p>Breast Imaging/Mammography</p> <input type="checkbox"/> Comprehensive <small>Approval to proceed to additional imaging and/or ultrasound to complete Breast Health assessment</small> <input type="checkbox"/> Screening <input type="checkbox"/> Diagnostic Date of last Mammogram: _____ Where: _____	Indicate area of interest below: <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> Right  </div> <div style="text-align: center;"> Left  </div> </div> <input type="checkbox"/> Implants	<div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <input type="checkbox"/> CT – Contrast Per Protocol <input type="checkbox"/> With 3D Reconstruction <input type="checkbox"/> DEXA <input type="checkbox"/> Genetics Consult <input type="checkbox"/> Interventional Radiology <input type="checkbox"/> MRI – Contrast Per Protocol <input type="checkbox"/> Arthrogram </div> <div style="width: 48%;"> <input type="checkbox"/> Nuc Med <input type="checkbox"/> PET <input type="checkbox"/> Ultrasound <input type="checkbox"/> X-Ray </div> </div>	
<input type="checkbox"/> Abdomen <input type="checkbox"/> Abdomen and Pelvis (CT only) <input type="checkbox"/> Aorta – US only <input type="checkbox"/> Arterial Doppler – US only <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Arm <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Ankle <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Bone Scan (Nuclear Medicine) <input type="checkbox"/> Limited area _____ <input type="checkbox"/> Total Bone <input type="checkbox"/> 3 Phase for infection <input type="checkbox"/> Brain <input type="checkbox"/> Breast <input type="checkbox"/> Calcium Scoring (CT only) <input type="checkbox"/> Carotid Doppler (US only) <input type="checkbox"/> Cardiac <input type="checkbox"/> Chest <input type="checkbox"/> Elbow <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral	<input type="checkbox"/> Extremity – Lower <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Bone <input type="checkbox"/> Non-Joint <input type="checkbox"/> Soft Tissue <input type="checkbox"/> Extremity – Upper <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Bone <input type="checkbox"/> Non-Joint <input type="checkbox"/> Soft Tissue <input type="checkbox"/> Facial <input type="checkbox"/> Femur <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Finger _____ <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Foot <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Forearm <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Gastric Emptying <input type="checkbox"/> Hand <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Head <input type="checkbox"/> HIDA Scan <input type="checkbox"/> Hips <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Humerus <input type="checkbox"/> IACs – Internal Auditory Canals	<input type="checkbox"/> IVP w/wo & 3D Reconstruction <input type="checkbox"/> Knee <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Lung – Low Dose Cancer Screening (CT only) <input type="checkbox"/> MRCP <input type="checkbox"/> Neck Soft Tissue <input type="checkbox"/> OB <14 weeks (US only) <input type="checkbox"/> OB >14 weeks (US only) <input type="checkbox"/> Orbits <input type="checkbox"/> Pelvis <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Pelvis w/ Transvaginal US if indicated <input type="checkbox"/> Pituitary <input type="checkbox"/> Prostate <input type="checkbox"/> PVR w/ Segmental Pressures <input type="checkbox"/> Renal <input type="checkbox"/> Doppler <input type="checkbox"/> Pre/Post Void Bladder <input type="checkbox"/> Retroperitoneal <input type="checkbox"/> Ribs <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Sacrum / Coccyx	<input type="checkbox"/> Shoulder <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Sinus <input type="checkbox"/> Spine <input type="checkbox"/> C-Spine – Prior Spine Surgery <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> L-Spine – Prior Spine Surgery <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> T-Spine – Prior Spine Surgery <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Testicular <input type="checkbox"/> Thyroid <input type="checkbox"/> Tibia/Fibula <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Toe _____ <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Venous Doppler – DVT <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Whole Body (Gallium Scan) <input type="checkbox"/> Wrist <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral <input type="checkbox"/> Other _____

Appointment Day:	Date:	Time:
Physician Name:	Phone:	
Physician Signature:	Date:	