CT/MRI Imaging Request Form

Patient Name: ______________________________ Date of Birth: ______________

To Schedule, Please Call: (801) 581-7840 *(M-F 8:00am-7:00pm)* **Please Fax All Orders To: (801) 585-9220**
Web Site: www.healthcare.utah.edu/radiology/refer-patient
Exam Requested: (**Check all that apply**)

CT IMAGING

EXAM(S):______________________________

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(Please indicate CTA if needed)

IV CONTRAST:
- ☐ WO IV CONT
- ☐ W IV CONT
- ☐ RADIOLOGIST TO DETERMINE

IV CONTRAST ALLERGY: (IODINE)
- ☐ YES
- ☐ NO

EASY TO PLACE IV:
- ☐ YES
- ☐ NO

ON DIALYSIS:
- ☐ YES
- ☐ NO

ABLE TO STAND AND WALK:
- ☐ YES
- ☐ NO

MRI IMAGING

EXAM(S): ______________________________

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(Please indicate MRA if needed)

IV CONTRAST:
- ☐ WO IV CONT
- ☐ WWO IV CONT
- ☐ RADIOLOGIST TO DETERMINE

IV CONTRAST ALLERGY: (GADOLINIUM)
- ☐ YES
- ☐ NO

CLAUSTROPHOBIC:
- ☐ YES
- ☐ NO

EASY TO PLACE IV:
- ☐ YES
- ☐ NO

ON DIALYSIS:
- ☐ YES
- ☐ NO

ABLE TO STAND AND WALK:
- ☐ YES
- ☐ NO

STIMULATOR (DBS/VNS/OTHER):
- ☐ YES
- ☐ NO

PACEMAKER/ICD:
- ☐ YES
- ☐ NO

SHUNT:
- ☐ YES
- ☐ NO

NON-CARDIAC STENT:
- ☐ YES
- ☐ NO

ANEURYSM CLIPS:
- ☐ YES
- ☐ NO

REASON FOR EXAM: ______________________________

DIAGNOSIS: ______________________________

SPECIAL INSTRUCTIONS: ______________________________

REFERRING PHYSICIAN NAME (*PLEASE PRINT*): ______________________________

REFERRING PHYSICIAN NPI: ____________________ TAX ID: ____________________

PHONE: ____________________ FAX (*FOR RESULTS*): ____________________

INSURANCE AUTHORIZATION#: ____________________ EXPIRATION: ______________

REFERRING PHYSICIAN SIGNATURE (*REQUIRED*):____________________ DATE: __________

Please include make and model of patient's implant(s), if possible. Also, please include patient demographic sheet, and copy of patient's insurance card(s) front and back when faxing in order form.