Hilo Medical Center
We Care for Our Community

Patients may be contacted by HMC Admitting for additional registration information.

DIAGNOSTIC IMAGING REQUISITION

DEPARTMENT OF IMAGING

To schedule an appointment please call:
974-6840 / 974-6841
Fax completed forms to:
935-1889

ver 20080422

MEDICAL REC. NO.	ACCOUNT NO.	PATIENT SOC. SEC. NO.	DATE OF SERVICE

PATIENT'S NAME (PLEASE PRINT) (LASTNAME) (OTHER NAME) (FIRST NAME) (M.I.)	BIRTHDATE	AGE

PATIENT'S ADDRESS	SEX ☐M ☐F	LMP

CITY, STATE, ZIP	PATIENT'S PHONE	WT.	FOR FEMALE PATIENTS PREGNANT ☐ YES ☐ NO

PATIENT INSURANCE INFORMATION

Insurance Carrier:_____ Membership Number:_____

Pre-Approval: ☐Yes ☐Pending: Pre-Approved By: _____

VA Exam Approval #:_____W/C: ☐ No-Fault: ☐ Date of Injury:_____

Authorization Number:_____ Adjuster's Name:_____

If Workman's Comp, Name of Employer:_____

DIAGNOSIS

DIAGNOSIS:

ICD 9 Code:

PROCEDURES

CPT-4 Codes:

☐ **ROUTINE** ☐ **URGENT (48 hours)** ☐ **EMERGENT (test immediate)**

PRELIMINARY REPORT TO (FAX NO.)	FINAL REPORT TO (FAX NO.)	CALL REPORT TO	PGR:
FAX ☐	**FAX** ☐	**PHONE** DR.	TEL:

OTHERS: ☐**REPORT CC TO:**
☐**SEND FILMS TO:**

☐ **XRAY** ☐ **CT** ☐ **ULTRASOUND** ☐ **NUCLEAR MED** ☐ **MRI** ☐ **SPECIAL PROCEDURES**

EXAM 1	**EXAM 3**
EXAM 2	**PREP**

SCHEDULING INFORMATION	SCANNING PROTOCOL
Appointment Date: _____ Appointment Time:_____ Arrival Time:_____	☐Routine: ☐Other:

CLINICAL HISTORY / INFORMATION

Previous Surgery in area of scan:_____

Previous Comparison Studies: ☐NO ☐YES If yes, please check: ☐MRI ☐CT ☐X-RAY ☐US ☐NM

Location and Date of Previous Studies, if known:_____

Previous films and reports will be transported to Hilo Medical Center by: ☐ Courier ☐ Mail ☐Patient

Known Allergies: _____

PLEASE FILL IN BELOW FOR MRI

ABSOLUTE CONTRAINDICATIONS			RELATIVE CONTRAINDICATIONS		
Cardiac Pacemaker	☐YES	☐NO	Pregnancy	☐YES	☐NO
Cerebral Aneurysm	☐YES	☐NO	Claustrophobia	☐YES	☐NO
Neurostimulator	☐YES	☐NO	History of Orbital Foreign Body	☐YES	☐NO

This is a medically necessary procedure. ☐Yes ☐ No (If both are blank, "No" will be used.)

Ordering Physician: _____ _____ _____
Printed Name Signature Date

Completed forms can not be saved or emailed. Please print/fax directly.