HALE PAWA'A

PHONE: (808) 591-1504
FAX: (808) 591-1506
1401 S. BERETANIA ST. #107
HONOLULU, HI 96814

3TMRI • CT APPOINTMENT

DATE: _____ ○ PATIENT CLAUSTROPHOBIC? PATIENT FOLLOW-UP

TIME: _____ ○ PACEMAKER OR METAL IMPLANTS? _____

PATIENT INFO AND INSURANCE

LAST: _____ FIRST: _____ ○ MALE ○ FEMALE

DOB: _____ HEIGHT/WEIGHT: _____ PHONE: _____

INSURANCE CARRIER: _____ AUTH #: _____

IF WORKERS COMP/AUTO PLEASE FILL OUT THE FOLLOWING: ○ WORK COMP ○ AUTO

DATE OF ACCIDENT: _____ CLAIM #: _____ EMPLOYER: _____

MRI REQUEST

HEAD AND NECK

- ○ BRAIN
- ○ IAC'S
- ○ PITUITARY
- ○ ORBITS
- ○ FACE
- ○ NECK (SOFT TISSUE OR NASOPHARYNX)
- ○ OTHER (SPECIFY)

_____

○ MRA ○ MRV

- ○ INTRACRANIAL (HEAD)
- ○ EXTRACRANIAL (NECK)
- ○ OTHER (SPECIFY)

_____

SPINE

- ○ CERVICAL
- ○ THORACIC
- ○ LUMBAR
- ○ SACRUM / SI JOINTS

MUSCULOSKELETAL

- ○ JOINT (SPECIFY)

_____

- ○ OTHER (SPECIFY)

_____

IV CONTRAST

- ○ YES
- ○ NO
- ○ PER RADIOLOGIST

CT REQUEST

- ○ HEAD
- ○ TEMPORAL BONE / MASTOID
- ○ ORBITS
- ○ NECK SOFT TISSUE
- ○ CHEST
- ○ ABDOMEN / PELVIS
- ○ CT IVP W/WO
- ○ RENAL STONES W/O (KUB)
- ○ EXTREMITY (SPECIFY)

_____

- ○ OTHER (SPECIFY)

_____

CONTRAST

- ○ ORAL
- ○ IV
- ○ PER RADIOLOGIST

DIAGNOSIS OR REASON FOR EXAM

ICD10 CODE (REQUIRED): _____

DIAGNOSIS/INDICATION: _____

SYMPTOMS/COMPLAINTS: _____

MASS OR TUMOR ○ KNOWN ○ SUSPECTED PRIOR SURGERY: _____

REQUESTING PROVIDER _____ PHONE: _____

CC TO: _____ PHONE: _____

PROVIDER SIGNATURE: _____ DATE: _____