

Medical Record Number \_\_\_\_\_

Patient Name (Last Name, First Name MI): \_\_\_\_\_

Date of Birth \_\_\_\_\_  Male  Female

Height \_\_\_\_\_ Weight \_\_\_\_\_

Insurance Plan/FSC: \_\_\_\_\_

Member Insurance# \_\_\_\_\_

Required information needed to schedule:

Attending MD Name \_\_\_\_\_

UPIN #\* \_\_\_\_\_ Office Phone \_\_\_\_\_

Fax \_\_\_\_\_ PIC: \_\_\_\_\_

Patient's Phone (H/W/Cell) \_\_\_\_\_

Office contact person: \_\_\_\_\_

Email: \_\_\_\_\_

\*UPIN needed for physicians. † Referral #: Provide PCP to Specialist referral #.

ICD-9 Codes: \_\_\_\_\_

Diagnosis/Indications: \_\_\_\_\_

Urgency:  Stat  Routine\*

Requested Clinic / Procedure Date: \_\_\_\_\_

**Biopsy:**

- Head & neck  Chest  Abdomen  Pelvis  Thyroid
- Other: \_\_\_\_\_

**Drainages:**

- Paracentesis  Thoracentesis
- Abscesses:  Head & neck  Chest  Abdomen
- Pelvis

Other: \_\_\_\_\_

**Radiology Procedures by Modality**

**CT (Creatinine level needed within 30 days of exam date)**

Specify \_\_\_\_\_

- Chest  Abdomen  Pelvis

**MRI**

With Conscious Sedation

With General Anesthesia

Abdominal (specify) \_\_\_\_\_

Pelvic

Thyroid \_\_\_\_\_

Other: \_\_\_\_\_

**Ultrasound**

Abdominal (specify) \_\_\_\_\_

Pelvic

Thyroid \_\_\_\_\_

Other: \_\_\_\_\_

Physician Signature \_\_\_\_\_ (MD, DO, NP, PA) Date: \_\_\_\_\_

Scheduled Date: \_\_\_\_\_ Scheduled time: \_\_\_\_\_ AM / PM Location (Circle): **EUH** **EUHM**