Appointment Date ______________________
Time ______________________

Special Instructions__________________________________

Ph: (860) 585-3020
Fax: (860) 585-3743 Centralized Scheduling Department

DIAGNOSTIC SERVICES REQUEST FORM

TODAYS DATE______________________

PATIENT NAME ____________________________ DOB __________________ SEX □ M □ F
(LAST) (FIRST)

ADDRESS________________CITY__________ ZIP________ HOME PHONE______________CELL #______________

PRIMARY INSURANCE/ID # ______________________ SECONDARY INSURANCE/ID# ______________________

AUTHORIZATION #'s______________________

ORDERING M.D. ____________________ COPY TO M.D. ________________ COPY TO M.D. ________________

RADIOLOGY
- ☐Abdomen ☐Chest
- ☐Extremity (Specify) _________________
- ☐Hip (Specify) ______________________ _
- ☐Pelvis ☐IVP
- ☐Spine (Specify) ____________________
- ☐Barium Enema □ with air
- ☐Barium Swallow □ with speech
- ☐GI's ☐Small Bowel Series
- ☐Other ___________________________
- ☐**Contrast Allergy**__________________
- ☐**EEG**

ULTRASOUND
- ☐Abdomen (Specify) _________________
- ☐Amniocentesis
- ☐Aorta
- ☐Breast (Specify) ____________________
- ☐Carotid Artery
- ☐Leg (Specify) _______________________
- ☐Pelvis /Transvaginal if Necessary
- ☐Pregnancy/ wks. _____________________
- ☐Renal
- ☐Thyroid
- ☐Other______________________________

CT SCAN
- ☐Abdomen ☐Abdomen/Pelvis □Chest
- ☐Pelvis □Head □Cervical ☐Lumbar
- ☐Extremity w**ith 3D reconstruction if needed**
- ☐Other____________________________
- *__**Contrast** ☐ with ☐ without ☐ with & w/out__
- ☐**Diabetic** ☐**Contrast Allergy**___________

NUCLEAR MEDICINE
- ☐Bone Scan (Specify) ___________________
- ☐Gastric Emptying
- ☐ HIDA Scan ☐ MUGA
- ☐Thyroid Scan □ Thyroid Uptake
- ☐VQ Lung Scan
- ☐PET Scan □ **Diabetic**
- ☐Other __________________________

Patients weight __________
- ☐Cardiolite Stress
- ☐Persantine Stress

CARDIO-PULMONARY
- ☐Stress ☐Echo ☐EKG
- ☐Holtor Monitor
- ☐Pulmonary Function Test ☐with ABG's
- ☐Vascular Arterial Study_____________
- ☐Other____________________________

MRI
- ☐Abdomen ☐Brain ☐Pelvis
- ☐Breast (Specify) __________________
- ☐Extremity (Specify) _________________
- ☐Hip (Specify) _____________________
- ☐Cervical □Lumbar □Thoracic Spine
- Other______________________________
- *__**Contrast** ☐with ☐ with out ☐with & w/out__

__***MRA**__
- ☐Abdomen ☐Brain ☐Carotid Artery
- ☐Extremity (Specify) ________ □Bilateral
- ☐Renal ☐Other___________________
- ☐ **with 3D reconstruction if needed**
- ☐**Diabetic** □**Contrast Allergy**__________

*Lab work required on all patients:
- ·Age 60 or above ·Diabetic
- ·Gout/Hyperuricemia ·Hypertension
- ·Pre-existing kidney disease or surgery
- □ **BUN** __________
- □ **CREATININE** __________

Diagnosis, Symptoms, and/or History

BEEKLEY CENTER SERVICES

MAMMOGRAPHY
- ☐Screening w/ US for dense breast tissue > 50 %
- ☐Diagnostic w/ US for dense breast tissue > 50%
- ☐Unilateral (R) (L) w/ US for dense breast tissue > 50%

Previous BH BRC OTHER Date______________

DENSITOMETRY
- ☐Bone Density Scan**:** ______________________

Previous BH BRC OTHER Date______________

ULTRASOUND
- ☐Breast (Specify) (R) (L) BILAT __________________

BREAST BIOPSIES
- ☐ L or ☐ R Breast Ultrasound Guided Biopsy ______________________
- ☐ L or ☐ R Breast Stereotactic Mammogram Guided Biopsy ______________________

Physician's Signature ________________________________

Centralized Scheduling Instructions:
Routine: Call 860-585-3020
Mon-Wed 8am-6pm Thurs 8am-7pm Fri 8am-5:30pm
After Hours: Fax completed Fax Order to 860-585-3743
STAT: Call Centralized Scheduling 860-585-3020

Patients should call 3 days before appointment to pre-register 860-585-3786
Hours to call: Mon-Thurs 8:30am-7:30pm

BH 2193 (Rev. 05/2014)