Medical Imaging

Scheduling
PH: 937-641-4000 Option 1 • Fax: 937-641-5405 • childrensdayton.org
Main Campus: One Children's Plaza • Dayton, OH 45404
South Campus: 3333 West Tech Road • Miamisburg, OH 45342

PLEASE PRINT (ALL INFORMATION IS REQUIRED)

PATIENT INFORMATION

Patient's Name: ______________________________
M F DOB: ______________________________
Parent/Guardian Name(s): ______________________
Primary Phone: ______________________________
Patient is in custody of: Parents Guardian CSB

Verify precertification prior to testing.

1st Insurance:______________ID# ______________
Precert # ____________ CPT Code ____________
2nd Insurance:______________ID#______________
Precert # ____________ CPT Code ____________

REFERRING PROVIDER INFORMATION

Referring Provider (PRINT): ______________________
Call to: ______________ Fax to: ______________
Copy to: ______________________________
Provider Address (Use office stamp in this space):

Provider Phone: ______________________________
Provider Signature: ______________________________
(required)

STAT **Same Day** **Call Results** **Fax Results**

REASON FOR TESTING

ICD-10 Code:____
Reason for Exam / Significant History / Symptoms / Diagnosis
1. ____
2. ____

X-Ray (walk-in)

Abdomen/KUB
Abdomen 2view
CXR
Sinus
Extremity
__RT__LT
Specify ______
Spine
__C __T__LS
Scoliosis

Other ________

Fluoroscopy
with appointment

UGI
Small bowel
Swallow Function
Esophagram
VCUG
Cath UA
ICD _____
Urinalysis
(Reflex Micro)
Urine Culture
IVP
Barium enema

Other ______

Ultrasound

Pyloric (<6-8wks)
Appendix
Breast
Gallbladder/RUQ
Abdomen
Renal/Bladder
Pelvic
Scrotum with doppler
Thyroid
Cerebral (<4mos)
Hips (<4mos)
Vascular
__RT__LT
Specify ext ______

Other __________

CT Scan
with appointment

Abd & Pelvis
Abdomen only
Pelvis only
Chest
Head
Sinus
Spine
__C__T__LS
Extremity
__Upper RT
__Lower RT
__Upper LT
__Lower LT

Other _______

****MRI **MRA**
with appointment

Patient HT ___________
Weight ______________
Abd & Pelvis
Abdomen only
Pelvis only
Chest
Brain
Fetal
Hip __RT__LT
Knee __RT__LT
Shoulder __RT__LT
Spine
__C__T__LS
__Total spine
Cardiac

Other ___________

Nuclear Medicine
with appointment
(Main Campus Only)

Bone scan – Whole body
Bone scan w/ Flow (3 phase)
Bone scan w/ SPECT
Lasix renal scan
__Hydration __ Catheter
Hepatobiliary scan
____w/o CCK
____w/ CCK
Gastric emptying scan
__Liquid__Solid
Thyroid uptake scan
Nuclear cystogram

Other ___________

MRI: Implant identification required prior to test.

Our goal is to process referrals within two business days. If unable to contact family within one week, we will notify your office.

Dayton Children's use only:

Scheduling Notes:

Appt Sched:
Date: ____________Time: ________________
Spoke With: Mother Father Guardian