CHENAL MRI

PATIENT REFERRAL FORM

Today's Date:_____

Procedure:_____

Appointment Date:_____**Time:**_____

Name:_____

Address:_____

_____**Zip:**_____

Place of Employment:_____

Home Phone:_____

Cell Phone:_____

Work Phone:_____

SS#:_____

DOB:_____ **Gender: M**_____**F**_____

Office Contact:_____

Referring Physician Label:

Reading Radiologist:_____

Primary Ins:_____

Policy or Claim #:_____

Group #:_____

Ins. Phone #:_____

Policy Holder:_____

Relationship:_____ **DOB:**_____

Place of Employment:_____

Secondary Ins: _____

Policy #:_____

Group #: _____

Ins. Phone #:_____

Policy Holder:_____

Relationship:_____ **DOB:**_____

Place of Employment:_____

Referring Physician Diagnosis: _____

_____

If W/C, authorization attached: Y / N

If VA, W/C, Auto – DOA:_____

GABHC #: _____

Primary / Secondary

Pre-cert auth #:_____/_____

Contact:_____/_____

Deductible:_____/_____

Amount Met: _____/_____

Plan Coverage:_____/_____

Est. Co-Ins: _____/_____

Co-Pay: _____/_____

Effective Date:_____/_____

Attorney name:_____

Attorney phone:_____

Same Day Scheduling :

Films requested by M.D.: Yes / No
Mail _____
Fed-Ex _____
Courier _____

Claustrophobic:	**Y**	**N**
Surgery:	**Y**	**N**
Cancer:	**Y**	**N**
Pacemaker:	**Y**	**N**
Clips or Metal:	**Y**	**N**
Implants:	**Y**	**N**

Weight:_____