Medical Imaging – Main & South Campus

Scheduling
PH: 937-641-4000 Option 1 • Fax: 937-641-5405
One Children's Plaza • Dayton, OH 45404-1815 • childrensdayton.org

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
☐ 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
☐ 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**
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
(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 _____

EKG (walk-in)
☐ Special Instructions

Cardiac ECHO (by Appointment ONLY)
☐ Special Instructions

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