RADIOLOGY SCHEDULING FORM

Fax# 818.902.5139 or Scheduling Questions Contact Tel#:818.902.5200

Date of Procedure:_______________ Requested Time:_______________ Length:___________________

Last Name: _________________________________ First Name ____________________________________

Date of Birth:________________ Gender: ☐ Male ☐ Female Social Security #:________________

Primary Language: ☐English ☐ Spanish ☐ Other ____

Allergies ____ HT __________ WT ___________

Address:___________________________City:_____________________State:_____Zip Code___________

Phone Number (Primary): ______________________ Alternate Phone ___________________________

Parent/Guardian/Facility Name:____

Radiologist: ______________________________________Request Assistant ☐Yes ☐No: ________________

Diagnosis: ____

ICD-10 ____ **CPT Code** ____________________________

Procedure:

____

Anesthesia Type ☐ MAC ☐ Moderate Sedation ☐ Local ______________________________________

Comorbidities: (Select all that apply) ☐ None ☐ Cardiac/Vascular Disease/Hypertension ☐ Endocine/Diabetes/Thyroid Disease ☐ Respiratory Disease (Smoker/Sleep Apnea) ☐ Kidney Disease ☐ Liver Disease ☐ Neurologic Disease ☐ Hematologic/Bleeding Disorders

Insurance Name ____________________________________**Policy Number** __________________________

Insurance Type ☐ HMO ☐ PPO ☐MediCare☐MediCal

If **HMO IPA** Name ____ **Days Approved**: ____________

Authorization Number:_________________________________ ☐ N/A Exp. Date_____________________

PLEASE ATTACH A COPY OF AUTHORIZATION, IDENTIFICATION CARD, COPY OF INSURANCE CARD(S) (Front & Back)

Images sent with Patient: ☐ NONE____

Special Equipment (Implants/Hardware): ☐ NONE____

Vendor /Rep ☐ None ____

Tel:___________________________________ Email____

Please attach H&P (within 30 days), orders and labs (within 2 weeks).

VALLEY PRESBYTERIAN HOSPITAL