Hilo Medical Center
We Care for Our Community

OUTPATIENT IMAGING ORDER REQUISITION

IMAGING DEPARTMENT

Phone Number: (808) 932-3800 | Fax Number: (808) 935-1889

PATIENT DEMOGRAPHICS

LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE	AGE

ADDRESS	SEX ☐ M ☐ F	LAST PERIOD?

CITY	STATE	ZIP	PHONE NUMBER	WEIGHT	PREGNANT ☐ YES ☐ NO

PATIENT INSURANCE INFORMATION

Primary Insurance:		Pre-Approval: ☐ Yes ☐ Pending	
Member Number:		**Hard copy of prior authorization required before scheduling.**	
Secondary Insurance:		W/C: ☐ No-Fault: ☐	Date of Injury:
Member Number:		Auth/Claim #:	Adjuster Info:

DIAGNOSIS

WRITTEN DIAGNOSIS:

ICD 10 Code(s):

PROCEDURES

CPT Codes:

☐ ROUTINE ☐ URGENT (48 HOURS) ☐ STAT (24-48 Hours)

FAX PRELIM REPORT TO FAX #:	FAX FINAL REPORT TO FAX #:	CALL PRELIM REPORT TO Dr. PHONE: PAGER:

Cc REPORT TO: SEND IMAGES TO:

☐ **CT** ☐ **CTA** ☐ **MRI** ☐ **MRA** ☐ **NM** ☐ **ULTRASOUND** ☐ **XRAY** ☐ **SPECIAL PROCEDURES**

EXAM 1:	EXAM 3:
EXAM 2:	PREP:

☐ **Interventional Radiology CONSULT** Direct Phone # for Ordering Provider:

REASON FOR CONSULT:

APPROPRIATE USE CRITERIA (AUC) Required for CT, CTA, MRI, MRA, NM

Vendor:

ID Number:	**Appropriateness:**

APPOINTMENT INFORMATION *To be completed by Imaging staff*		**NOTES**
Appointment Date:		
Appointment Time:		
Check-In Time:		

SURGICAL & IMAGING HISTORY

Surgery in area of scan? ☐ NO ☐ YES If yes, what type and when?

Comparison Studies: ☐ NO ☐ YES If yes, please check: ☐ MRI ☐ CT ☐ X-RAY ☐ US ☐ NM

Location and Date of Previous Studies, if known:

Previous films and reports will be transported to HMC BY: ☐ Courier ☐ Mail ☐ Patient

Known Allergies:

FOR CT

Fax hard copy of Lab results done within 30 days of contrast appointment

History of renal disease? ☐ NO ☐ YES

BUN: CREATININE: GFR:

Date of Lab results:

Must be done within 30 DAYS of contrast appointment.

If the patient is on dialysis, what is their dialysis schedule?

Day: Time:

FOR MRI

Please do not fax unless the information below is completed

Cardiac Pacemaker or ICD	☐ NO	☐ YES
Biostimulator Implant	☐ NO	☐ YES
Claustrophobic	☐ NO	☐ YES
Aneurysm Surgery	☐ NO	☐ YES
History of Cancer	☐ NO	☐ YES
History of Foreign Body in EYES	☐ NO	☐ YES

Signature _____ Date: Ordering Provider's Printed Name: