EMORY HEALTHCARE

Emory Department of Radiology & Imaging Sciences
Radiology Procedure Scheduling
Phone: 404-712-0566
Fax: 404-712-7122
Office Hours 7:30am-5pm,Monday-Friday

Medical Record Number _____
Patient Name *(Last Name, First Name MI)***:**
_____

Date of Birth_____ **□Male □Female**
Height_____**Weight**_____
Insurance Plan/FSC:_____
Member Insurance#_____
_____

Required information needed to schedule:
Attending MD Name _____
UPIN #***** _____ **Office Phone** _____ ____
Fax _____ **PIC:** _____
Patient's Phone *(H/W/Cell)* _____

Office contact person: _____

Email: _____

*****_UPIN_ *needed for physicians.* †_Referral #_*: Provide PCP to Specialist referral #.*

ICD-9 Codes:_____
Diagnosis/Indications:_____
_____

Urgency: □ Stat □ Routine* **Requested Clinic / Procedure Date:**_____

□ **Biopsy**:
□ Head & neck □ Chest □ Abdomen □ Pelvis □ Thyroid
□ Other:
_____
_____
_____
_____
_____
_____
_____
_____
_____

□ **Drainages**:
□ Paracentesis □ Thoracentesis
□ Abcesses**:** □ Head & neck □ Chest □ Abdomen □ Pelvis

□**Other**:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Radiology Procedures by Modality

□ **CT (Creatinine level needed within 30 days of exam date)**
Specify _____
□ Chest □ Abdomen □ Pelvis

□ **MRI**
□ **With Conscious Sedation**
□ **With General Anesthesia**
□ Abdominal (specify) _____
□ Pelvic
□ Thyroid _____
□ Other:
_____
_____
_____

□ **Ultrasound**
□ Abdominal (specify) _____
□ Pelvic
□ Thyroid _____

□ Other:
_____
_____
_____
_____

Physician Signature_____ *(MD, DO, NP, PA)* Date: _____

Scheduled Date:_____ Scheduled time: _____ AM / PM Location (Circle): **EUH** **EUHM**