RADIOLOGY ASSOCIATES of HARTFORD, P.C.

LOCATION: ❑ Avon 860-409-1952 ❑ Enfield 860-714-9410 ❑ Glastonbury 860-714-9710

Patient Name: ______________________ DOB: ____________ Date: ____________

Appointment Date: ________ Appointment Time: ________ Referring MD: ______________ cc: ________

Insurance: ______________ Insurance ID #: ______________ Precertification #: ______________

CLINICAL INFORMATION: (please specify signs/symptoms)

Referring Physician Signature: ______________________ **(required)**

Previous films: ❑ Yes ❑ No **Location of Films:** ______________________

Clinical Questions:

Does the patient have impaired renal function? ❑ Yes ❑ No BUN: ____________

Serum Creatinine (required for CT patients over 60 years old or diabetic): ____________ Date Drawn: ________

Glomerular Filtration Rate (GFR) (required for patients having MRI with contrast): ________ Date Drawn: ________

Is patient diabetic? ❑ Yes ❑ No If yes, list medications: ______________

Previous reaction to contrast? ❑ Yes ❑ No If yes, explain: ______________

Does patient have any allergies? ❑ Yes ❑ No If yes, specify allergy: ______________

LMP: ________ Is patient pregnant? ❑ Yes ❑ No

Is patient taking blood thinners? ❑ Yes ❑ No If yes, list medications: ______________
(e.g. Coumadin, Aspirin, Plavix, etc.)

EXAMS:

◇ **MRI**
- ☐ Head
- ☐ C-Spine
- ☐ L-Spine
- ☐ Shoulder
- ☐ Knee
- ☐ Hip
- ☐ Wrist
- ☐ Pelvis
- ☐ Other

◇ **MRA**
- ☐ Head
- ☐ Neck
- ☐ Carotid

◇ **CT**
- ☐ Head
- ☐ Sinus
- ☐ Abdomen
- ☐ Abdomen/Pelvis
- ☐ Pelvis
- ☐ Chest
- ☐ Lumbar Spine
- ☐ Other

◇ **CTA**
- ☐ Head
- ☐ Neck
- ☐ Chest
- ☐ Abdomen
- ☐ Pelvis

◇ **Ultrasound**
- ☐ Abdomen
- ☐ Aorta
- ☐ Breast
- ☐ Deep Venous Leg
- ☐ Pelvis
- ☐ Pregnancy
- ☐ (1st trimester)
- ☐ Renal
- ☐ Testicular
- ☐ Thyroid
- ☐ Transvaginal
- ☐ Other

◇ **Mammography**
- ☐ Diagnostic
- ☐ Screening

◇ **Surgical**
- ☐ USG Breast Biopsy
- ☐ Sclerotherapy
- ☐ Endovenous Laser Treatment
- ☐ Thyroid Biopsy
- ☐ Other

◇ **Bone Density**
- ☐ Hip and Spine

◇ **General X-ray**
- ☐ Chest PA and LAT
- ☐ Abdomen
- ☐ Cervical Spine
- ☐ Dorsal Spine
- ☐ Lumbar Spine
- ☐ Hip
- ☐ Pelvis
- ☐ Foot
- ☐ Ankle
- ☐ Knee L☐ R☐
- ☐ Hand
- ☐ Wrist
- ☐ Shoulder
- ☐ Other

☐ with contrast ☐ without contrast ☐ with and without contrast

☐ **Other exam order:** ______________________ **Tech Initials:** ________
(please print)

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